DEPARTMENT OF THE ARMY
UNITED STATES ARMY CRIMINAL INVESTIGATION COMMAND
CAMP BUCCA CID OFFICE, 380TH MILITARY POLICE DETACHMENT
CAMP BUCCA, IRAQ APO AE 09375

REPLY TO
ATTENTION OF

CIRB-BAD

13 Nov 05

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION – FINAL (C) - 0073-05-CID579-40022 – 5H9A

DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 27 JUL 2005/1529 - 27 JUL 2005/1529; INTENSIVE CARE WARD (ICW), INTERNMENT FACILITY AID STATION (IFAS), THEATER INTERNMENT FACILITY (TIF), CAMP BUCCA, IRAQ APO AE 09375 (CBI), GRID 38S MB 130840

DATE/TIME REPORTED: 27 JUL 2005, 1539

INVESTIGATED BY: SA (b)(2),(b)(6),(b)(7)(C) SA (b)(2),(b)(6),(b)(7)(C) SA (b)(2),(b)(6),(b)(7)(C)

SUBJECT: 1. NONE; [NATURAL DEATH].

VICTIM: 1. ATAWI/AL ALWANI, AHMED ISMAIL (DECEASED); CIV/DETAINEE; INTERNMENT SERIAL NUMBER (ISN) (b)(6),(b)(7)(C) JAN 1975; FALLUJAH, IRAQ; M; OTHER; TIF, CBI; [NATURAL DEATH].

INVESTIGATIVE SUMMARY:

This is an "Operation Iraqi Freedom 2004-2006" investigation.

SPC (b)(6),(b)(7)(C) 344th Combat Support Hospital (CSH), CBI, reported Detainee ATAWI died in the ICW, Internment Facility Aid Station, CBI.

Investigation determined Detainee ATAWI died of Peritonitis due to a small bowel perforation. The manner of death was natural. Detainee ATAWI was hospitalized for 23 days prior to his death.

STATUTES:

Not Applicable

EXHIBITS/SUBSTANTIATION:

Attached: **b(2), b(6), b(7)(C)**

1. Agent's Investigation Report (AIR) of SA (b)(6),(b)(7)(C) 2 Nov 05, documenting the basis for investigation, interviews of medical personnel who provided Detainee ATAWI care and detainees who knew Detainee ATAWI, inspection of Detainee ATAWI's personal belongings, receipt of medical records, confirmation of Detainee ATAWI's identity, viewing of his remains, and receipt of the autopsy report.

2. Medical records of Detainee ATAWI.

3. Certificate of Death and Hospital Report of Death, 27 Jul 05, of Detainee ATAWI.

4. Autopsy Examination Report, 24 Oct 05, ME 05-700, which listed the cause of death as Peritonitis due to a small bowel perforation and the manner of death as natural.

5. AIR of SA (b)(6),(b)(7)(C) 4 Sep 05, documenting preliminary autopsy report findings and receipt of autopsy photographs.

6. Compact disk ME 05-700 containing digital images of the autopsy.

7. Preliminary Autopsy Report, ME 05-700, 6 Aug 05, which reflected the cause of death was Peritonitis and the manner of death was natural.

8. Compact disk 0073-05-CID579-40022, containing the originals of all digital images exposed by USACIDC during this investigation and an index describing selected images. (USACRC, AFIP, and file copies only)

Not Attached:

None.

The originals of Exhibits 1, 5 and 8 are forwarded with the USACRC copy of this report. The originals of Exhibits 2 and 3 are retained in the files of the IFAS, CBI. The originals of Exhibits 4, 6, and 7 are retained in the files of the Armed Forces Institute of Pathology (AFIP), Rockville, MD.

STATUS: This is a Final (C) Report. This investigation was terminated in accordance with CIDR 195-1, paragraph 4-17 (a) (8a). Medical authorities determined that Detainee ATAWI's death resulted from natural causes and there was no evidence to contradict their findings. Commander's Report of Disciplinary or Administrative Action Taken (DA Form 4833) is not required.

Leads Remaining: Receipt of an Addendum Report from AFIP describing the exact etiology of lesions adjacent to the bowel perforation. This finding will not affect the cause or manner of death. A supplemental report will be prepared upon receipt of the AFIP Addendum Report.

b(6), b(7)(C)

Report Prepared By:

(b)(6),(b)(7)(C)

Special Agent, (b)(2)

Report Approved By:

(b)(6),(b)(7)(C)

Special Agent in Charge

DISTRIBUTION:

USACRC, (ATTN: CICR-CR), Fort Belvoir, VA (original)
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SJA, CBI

b(2), b(6), b(7)(C)

518-124 STANDARD FORM 518 (REV. 9-92) NSN 7540-00-634-4165

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

0075-65-CID529-40022

MEDICAL RECORD — BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ Units)
- [ ] CRYOPRECIPITATE (Pool of _____ units)
- [ ] Rh IMMUNE GLOBULIN (RhIG)
- [ ] OTHER (Specify)

VOLUME REQUESTED (If applicable)

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [✓] TYPE AND SCREEN
- [✓] CROSSMATCH

DATE REQUESTED: 4 July 2005

DATE AND HOUR REQUIRED: 4 July 2005 / 1045hrs

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN:
HEMOLYTIC DISEASE OF NEWBORN?

REQUESTING PHYSICIAN (Print): (b)(6)

DIAGNOSIS OR OPERATIVE PROCEDURE: MALARIA

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label is correct.

SIGNATURE OF VERIFIER: (b)(6)

DATE VERIFIED: 14 July 2005

TIME VERIFIED: 1045 hrs

Exp Date: 16 July 05 2359

SECTION II – PRE TRANSFUSION TESTING

UNIT NO.: (b)(6)

(b)(6)

ICW

TRANSFUSION NO. OF PREVIOUS TRANSFUSIONS

PATIENT NO.: 166576

ANTIBODY SCREEN: NA

CROSSMATCH: Compatible

PREVIOUS RECORD CHECK:
- [X] RECORD OF EXAM
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TESTS: (b)(6)

DONOR	RECIPIENT
ABO: O	ABO: A
Rh: POS	Rh: POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE:

REMARKS:
No Antibody screen performed
Immediate spin crossmatch only

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY: (Signature) (b)(6)

DATE (Day) 14 July 05 TIME (Hour) 1404

IDENTIFICATION RECORD CHECK – CRITICAL STEP: Ensure blood is combined with correct patient

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1ST VERIFIER (Signature) (b)(6)

2ND VERIFIER (Signature) (b)(6)

PRE-TRANSFUSION: TEMP 97.6 | PULSE 91 | BP 86/56

DATE OF TRANSFUSION: 14 July 05 | TIME STARTED (Clock time) 14:44

POST-TRANSFUSION DATA

AMOUNT GIVEN: 250 ML

TIME/DATE COMPLETED/INTERRUPTED: 17'02 14 July 05

REACTION
- [X] NONE
- [ ] IS SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
97	94	90/60

If reaction is suspected – IMMEDIATELY DO the following:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [✓] NO
- [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)

PATIENT IDENTIFICATION – USE EMBOSSER (For typed or written entries give: Name – Last, first, middle; grade; rank; rate; hospital or medical facility)

SEX: M

WARD: ICW

166576

Awan, Ahmed

SECTION I – REQUISITION

INSTRUCTIONS FOR NON-SELF-EXPLANATORY ITEMS

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR; FIRMR (41 CFR) 201-9.202

Medical Record Copy

PRINTED ON RECYCLED PAPER

ACLU DDII CID ROIS 38885

000008

ACLU-RDI 5494 p.4

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

Exhibit 2

MEDICAL RECORD

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of 2L 210 units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN (RhIG) _____ mL
- [ ] OTHER *(Specify)*

VOLUME REQUESTED *(If applicable)*

REMARKS:

Exp: 16 July 05 2359

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 14 July 2005

DATE AND HOUR REQUIRED: 14 July 2005 1045 hrs

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN:

HEMOLYTIC DISEASE OF NEWBORN?

REQUESTING PHYSICIAN *(Print)*: (b)(6)

DIAGNOSIS OR OPERATIVE PROCEDURE: MASERA

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER: (b)(6)

DATE VERIFIED: 14 July 2005

TIME VERIFIED: 1045 hrs

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO.	TEST INTERPRETATION		PREVIOUS RECORD CHECK:
(b)(6)		ANTIBODY SCREEN	CROSSMATCH	[X] RECORD [ ] NO RECORD
ICW	166576	NA	Compatible	SIGNATURE OF PERSON PERFORMING TEST: (b)(6)
DONOR	RECIPIENT			
ABO: O	ABO: A	[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED		DATE
Rh: POS	Rh: POS			

REMARKS:
No Antibody screen performed
Immediate spin crossmatch only

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

RECEIVER *(Signature)*: (b)(6)

2nd VERIFIER *(Signature)*: (b)(6)

PRE-TRANSFUSION: TEMP. 97.4 F | PULSE 111 | BP 90/59

DATE OF TRANSFUSION: 14 July 05 | TIME STARTED: 12:35

PATIENT IDENTIFICATION – USE EMBOSSER *(For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)*: Component Requested 166576 Name, Ahmed

SEX: M | WARD: ICW

POST-TRANSFUSION DATA

AMOUNT GIVEN: 250 ML

TIME/DATE COMPLETED/INTERRUPTED: 14:40 14 July 2005

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	97.1	91	86/56

If reaction is suspected IMMEDIATELY DO the following in order listed:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: (b)(6)

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PRINTED ON RECYCLED PAPER

Medical Record Copy

ACLU DDII CID ROIS 38886

TASK FORCE MED 115 LABORATORY
Camp Bucca Internment Facility SASH, Iraq

LABORATORY FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI (Or Hospital ID #): Ataw Ahmed L
Physician:
Drawn by: (b)(6)
Ward: ICW
Bed: 12

Male / Female
SSN or ISN: 166576
STAT / Routine
Specimen Collection Date & Time: 13 Jul 05

Signs and Symptoms: Malaria
Lab Use Only
Initials: (b)(6)
Lab Use Only 2nd
D&T: 15 Jul 05

Chemistry (i-STAT): Syringe / Green Top
Bld Gas Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:		EPI:	
RBC:		Mucus:	
Bacteria:		Yeast:	
Casts:		Crystals:	
Other:			

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 uIU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests:
(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top
Chem 12 MetLyte CPK Liver Lipid Renal (b)(6)

TEST	RESULT	REF. RANGE
ALB	3.9	3.3-5.5 g/dL
ALP	21.0	26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST	20	11-38 U/L
Tbil	0.5	0.2-1.6 mg/dL
BUN	11	7-22 mg/dL
Ca	6.4 L	8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL	160	98-109 mmol/L
TCO2	27	18-33 mmol/L
Creat	0.8	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	90	73-118 mg/dL
K	3.5	3.3-4.9 mmol/L
TProtein	3.5 L	6.4-8.1 g/dL
Na	132	138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		<30 mg/dL
C/HDL RAT		<4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova // Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top
CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC	13.6	4.8-10.8 x10(3)/uL
RBC	3.98	4.2-6.1 x10(6)/uL
Hgb	9.0	12.0-18.0 g/dL
Hct	29.2	M: 42.0-52.0%
		F: 37-47%
MCV	73	80.0-99.0 fl
MCH	30.2	27.0-31.0 pg
MCHC	30.9	33.0-37.0 g/dL
Plt	431	130-400 x10(3)/uL
LY%	19.5	20.0-44.0%
LY#	2.52	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells
RBC Abn Morph:	
Plt Abn Morph:	
WBC Abn Morph:	

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG/0-107 ng/mL
CK-MB		NEG/0-4.3 ng/mL
Troponin		NEG/0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container
Fluid Panel includes: Gram stain, WBC & RBC count, WBC differential, and Microscopic Path (CSF only)

Exhibit 2

TASK FORCE MED 115 LABORATORY
Camp Bucca Internment Facility SASH, Iraq

LABORATORY FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. (Or Hospital ID #): Atawi Ismail Ahmed
Physician: Ward: 12 W
Drawn by: Bed: 12

✓ Male / Female
SSN or ISN: 166576
STAT / ✓ Routine
Specimen Collection Date & Time: 18 July 05

Signs and Symptoms: Malaria
Lab Use Only Initial: (b)(6)
Lab Use Only D&T: 18/1650Q535

Chemistry (i-STAT) Syringe / Green Top
Bld Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH		7.35-7.45
pCO2		35-45 mmHg
pO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 uIU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests:
(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top
Chem 12 / Metabolic / CMP / Liver / Lipid / Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN	7	7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK	35	M: 39-380 U/L
		F: 30-190 U/L
CL	94	98-109 mmol/L
TCO2	24	18-33 mmol/L
Creat	1.0	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	86	73-118 mg/dL
K	4.0	3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na	127	138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hepatology (Coulter): Purple Top
CBC / Manual Differential

TEST	RESULT	REF. RANGE
WBC	14.1	4.8-10.8 x10(3)/uL
RBC	3.77	4.2-6.1 x10(6)/uL
Hgb	8.6	12.0-18.0 g/dL
Hct	27.6	M: 42.0-52.0%
		F: 37-47%
MCV	73.2	80.0-99.0 fl
MCH	22.7	27.0-31.0 pg
MCHC	31.1	33.0-37.0 g/dL
Plt	441	130-400 x10(3)/uL
LY%	16.9	20.0-44.0%
LY#	2.4	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Fluid Panel Includes: Gram Stain, WBC & RBC counts, WBC differential, and Meningitis Panel (CSF only)

Exhibit 2

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE 0073-05-CID579-40022

DOCTOR'S ORDERS - *(SIGN ALL ORDERS)*

For Each Set of Orders, Record the Date and Time. Sign, and Cross Out the Unused Lines

PATIENT IDENTIFICATION

166576

Atawi Ahmed Ismail

NURSING UNIT ICW | ROOM NO. | BED NO. 12

DATE OF ORDER 04 Jul 05 | TIME | NURSE'S SIGNATURE

Admit to ICW
Cond - Stable
Dx - W/U for Splenomegaly
Anemia, ↑ Platelets, ↑ Fatigue
x several months
VS - Routine
Diet Reg
Activities - Bathroom Privileges
F/U c FP/Internist in Clinic
in AM

(b)(6)

PATIENT IDENTIFICATION

166576

DATE OF ORDER

24° Chart

4 July 05 0800
UA
Monospot

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

166576

DATE OF ORDER | TIME

4 July 05 CSR, INR, PH, ASTALT ... (b)(6)
0900 [redacted]

(blood) Alfa fetoprotein level
✓ Hep A/B/C/D (b)(6)
[redacted] (b)(6)
✓ CBC LFT in Am
✓ urine Na

Seen 4 July 2005 1000

(b)(6)

NURSING UNIT ICW | ROOM NO. | BED NO. 12

24° Chart (b)(6) July 4

PATIENT IDENTIFICATION

166576

DATE OF ORDER 6 Jul 05 | TIME 1222

BMP, CHEM 12, CBC today (ASAP)
Serum Fe, Retic count, TIBC (b)(6)
Seen (b)(6)
Done by (b)(6) 1415 hrs

(b)(6)

(b)(6)

6 Jul 05

NURSING UNIT | ROOM NO. | BED NO. 12

AF FORM 3066-1, 19870401 (EF-V2)

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE PATIENT RECORD

0073-05-CID579-40022

DOCTOR'S ORDERS - *(SIGN ALL ORDERS)*

For Each Set of Orders. Record the Date and Time. Sign. and Cross Out the Unused Lines

PATIENT IDENTIFICATION

166576

Bed #12

Atawi Ahmed Ismail

NURSING UNIT ICU | ROOM NO. | BED NO. 12

DATE OF ORDER 06 July 05 TIME 1820 NURSE'S SIGNATURE natod (b)(6)

D CHANGE DIET ORDER TO RECOMMENDATIONS PER NUTRITION TEAM:
DOUBLE PORTIONS SUPPLEMENT SAUCE AT LUNCH
ENSURE PLUS WITH EACH MSAL
(CONTINUE FLUID RESTRICTION AT 2 LITERS PER DAY (b)(6)

(b)(6)

6 July 2005 1820hrs (b)(6)

PATIENT IDENTIFICATION

166576

NURSING UNIT ICU | ROOM NO. | BED NO. 12

DATE OF ORDER 06 July 05 TIME 2200

D Chlorozine Phosphate (ARALEN) PO
1000mg salt x1, now please @2300 (06 July)
then 500mg salt @ 0500 tomorrow (07 July)
@ 2300 tomorrow (07 July)
and then @ 2300 on 08 July (b)(6)

(b)(6)

PATIENT IDENTIFICATION

166576

NURSING UNIT ICU | ROOM NO. | BED NO. 12

DATE OF ORDER 07 Jul 05 TIME 0015

Morphine 6mg IV x1
Reglan 10mg IV x1
Benadryl 50mg IV x1 STAT

D/C IM ATC

(b)(6)

PATIENT IDENTIFICATION

166576

NURSING UNIT ICU | ROOM NO. | BED NO. 12

DATE OF ORDER TIME

7 Jul 05 no diet per nutrition please
~~no milk~~ see progress note ? diet

08 Jul 05
Reglan 10mg IV
Keflan 1g IV

(b)(6)

(b)(6)

(b)(6)

(b)(6)

(b)(6)

NURSING UNIT ICU | ROOM NO. | BED NO.

Exhibit 2

TASK FORCE MED 115 LABORATORY — LABORATORY FORM

Camp Bucca Internment Facility SASH, Iraq (Subject to Privacy Act of 1974)

LAST, FIRST, MI (Or Hospital ID #) ATAWI Ahmed Ismail	X Male / Female	SSN or ISN: 166576	Signs and Symptoms: Malaria
Physician: Ward: ICW	STAT	Specimen Collection Date & Time:	Lab Use Only Initials (b)(6) / Lab Use Only D&T: 18 July
Drawn by: Bed: 12	X Routine	18 July 05	

Chemistry (I-STAT): Syringe / Green Top

Bld Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 uIU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests: (Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top

Chem 12 MetLyte8 BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB	<1.0	3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN		7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL		98-109 mmol/L
TCO2		18-33 mmol/L
Creat		0.6-1.3 mg/dL
GGT		5-65 U/L
Glu		73-118 mg/dL
K		3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na		138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top

CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/uL
RBC		4.2-6.1 x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential, and Manual Differential (CSF only)

TASK FORCE MED 115 LABORATORY — LABORATORY FORM

Camp Bucca Internment Facility, ... Iraq — (Subject to Privacy Act of 1974)

ST, FIRST, MI, (Or Hospital ID #) ATANI, Ahmd	Male / Female	SSN or ISN: 166576
sician: Ward:	STAT	Specimen Collection Date & Time:
wn by: (b)(6) Bed: 12	Routine	

Signs and Symptoms: Malaria

Lab Use Only Initials: | Lab Use Only D&T:

mistry (i-STAT): Syringe / Green Top — Gas — Bld Gas w/Lact - Glu - Crea

EST	RESULT	REF. RANGE
		7.35-7.45
O2		35-45 mmHg
2		80-100 mmHg
O2		18-33 mmol/L
O3		22-26 mmol/L
2		95-99%
ecf		(-2) - (+3)
ctate		0.90-1.70 mmol/L
ucose		73-118 mg/dL
eat		0.6-1.3 mg/dL

Urinalysis

olor		Straw/Yellow
arity		Clear
ucose		Negative
lirubin		Negative
etone		Negative
G		1.010-1.025
ood		Negative
H		5.0-8.0
otein		Negative-Trace
obili		0.1-1.0 Ehrlich U/dL
trite		Negative
euko		Negative

Urine Microscopic

BC:	EPI:
BC:	Mucus:
acteria:	Yeast:
asts:	Crystals:
ther:	

pecial Chemistries / Red or Tiger Top

SH		0.25 - 5 uIU/ml
T4		9 - 20 pmol/L
T3		4.0 - 8.3 pmol/L
4		60 - 120 nmol/L
3		0.92 - 2.33 nmol/L
IV		Negative

dditional / Other Requests (Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top

Chem 12 Met Lytes (BMP) Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN	8	7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK	34	M: 39-380 U/L
		F: 30-190 U/L
CL	91	98-109 mmol/L
TCO2	24	18-33 mmol/L
Creat	0.8	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	83	73-118 mg/dL
K	3.8	3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na	130	138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top

(CBC) Manual Differential

TEST	RESULT	REF. RANGE
WBC	15.9	4.8-10.8 x10(3)/uL
RBC	3.63	4.2-6.1 x10(6)/uL
Hgb	8.3	12.0-18.0 g/dL
Hct	26.8	M: 42.0-52.0%
		F: 37-47%
MCV	73.1	80.0-99.0 fl
MCH	22.9	27.0-31.0 pg
MCHC	31.3	33.0-37.0 g/dL
Plt	122	130-400 x10(3)/uL
LY%	20.3	20.0-44.0%
LY#	3.2	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential, and ... (Meningitis Panel Only)

For Each Set of Orders, Record the Date and Time, Sign, and Cross Out the Unused Lines

PATIENT IDENTIFICATION

(b)(6)

8 Jul 05

166576

BED #12

DATE OF ORDER 08 July 2005 TIME 0930 NURSE'S SIGNATURE

Please change fluid restriction to 1L per day — noted (b)(6)

② Please give Lasix 20mg PO BID (1st dose now please) (b)(6)

③ Please draw Serum Renal QAM (b)(6)

(following up hyponatremia)

④ Please NOTIFY PHYSICIAN if Potassium (b)(6)

NURSING UNIT ROOM NO (b)(6)

PATIENT IDENTIFICATION

Afawi, Ahmed Ismail

DATE OF ORDER 08 JUL 05 TIME 2137 (b)(6)

① APAP 650mg q 4 hours PO PRN (b)(6)

(b)(6)

8 Jul 05

2139

(b)(6)

NURSING UNIT

PATIENT IDENTIFICATION

166576

DATE OF ORDER 09 July 05 TIME 1615

① ZOFRAN 4mg IVP BID prn nausea

② Please substitute CRACKERS/JELLO/CHEESE with other food items (detainee complains these contribute to his nausea)

③ Please add table salt to meals TID (b)(6) (b)(6)

~~④ Please draw Serum Albumin & Prealbumin~~

~~Magnesium Level pm~~

⑤ Multivitamin 1 PO QAM c breakfast

NURSING UNIT ROOM NO (b)(6)

PATIENT IDENTIFICATION

166576

(b)(6)

DATE OF ORDER 10 Jul 05 TIME 1100

No labs today

Resume daily renal panel tomorrow

CBC and Chem 12 every Mon + Thurs.

FeSO4 325 mg po bid

Colace 100 mg po bid

(b)(6)

(b)(6)

NURSING UNIT ROOM NO BED NO

TASK FORCE [redacted] FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

Camp Bucca Int[redacted]ment Fa[redacted]SH, Iraq (Subject to Privacy Act of 1974)

ST, FIRST, MI (Or Hospital ID #): Ahmed Ismail
sician: Ward: ICU
wn by: Bed: 12

Male / Female / STAT / Routine
SSN or ISN: 166576
Specimen Collection Date & Time: 21 July 05
Signs / Symptoms: Pain
Lab Use Only Initials:
Lab Use Only D&T:

mistry (i-STAT) Syringe / Green Top

TEST	RESULT	REF. RANGE
Gas - Bld Gas w/Lact - Glu - Crea		
		7.35-7.45
O2		35-45 mmHg
2		80-100 mmHg
O2		18-33 mmol/L
O3		22-26 mmol/L
2		95-99%
ecf		(-2) - (+3)
ctate		0.90-1.70 mmol/L
ucose		73-118 mg/dL
eat		0.6-1.3 mg/dL

Urinalysis

lor		Straw/Yellow
arity		Clear
ucose		Negative
lirubin		Negative
tone		Negative
G		1.010-1.025
ood		Negative
H		5.0-8.0
otein		Negative-Trace
obili		0.1-1.0 Ehrlich U/dL
trite		Negative
uko		Negative

Urine Microscopic

BC:	EPI:
BC:	Mucus:
acteria:	Yeast:
asts:	Crystals:
ther:	

pecial Chemistries / Red or Tiger Top

SH		0.25 - 5 uIU/ml
T4		9 - 20 pmol/L
T3		4.0 - 8.3 pmol/L
		60 - 120 nmol/L
3		0.92 - 2.33 nmol/L
IV		Negative

dditional / Other Requests

(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer) Green Top

Chem 12 Metlyte BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN	L	7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK	34 L	M: 39-380 U/L
		F: 30-190 U/L
CL	94 L	98-109 mmol/L
TCO2	23	18-33 mmol/L
Creat	1.0	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	92	73-118 mg/dL
K	3.9	3.3-4.9 mmol/L
T Protein		6.4-8.1 g/dL
Na	127 L	136-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		<4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter) Purple Top

CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC	18.6 H	4.8-10.8 x10(3)/uL
RBC	3.50 L	4.2-6.1 x10(6)/uL
Hgb	7.7 L	12.0-18.0 g/dL
Hct	25.6 L	M: 42.0-52.0%
		F: 37-47%
MCV	77.0	80.0-99.0 fl
MCH	22.6	27.0-31.0 pg
MCHC	30.5	33.0-37.0 g/dL
Plt	407	130-400 x10(3)/uL
LY%	15.4	20.0-44.0%
LY#	2.6	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S?		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG/0-107 ng/mL
CK-MB		NEG/0-4.3 ng/mL
Troponin-I		NEG/0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential, Cryptococcal Antigen

Meningitis Panel (CSF only)

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

Exhibit 2

FOR OFFICIAL USE ONLY/LAW ENFORCEMENT SENSITIVE

PATIENT IDENTIFICATION

166572

ATAWI Ahmed Ismail

NURSING UNIT ICU | ROOM NO. | BED NO. 12

DATE OF ORDER 11 Jul 05 TIME

Lasix 40 mg po daily

Noted (b)(6) 11 July 05 1000hrs

PATIENT IDENTIFICATION

166576

DATE OF ORDER 12 JUL 05 TIME 1100

Vit C 250 mg po bid c meals

Cosvi FeSO4 325 mg po bid c meals

Reglan 10 mg po qid - 30 mins before meals and at bedtime

D/C Zofran ✓ D/C IVF

(b)(6) 12 July 05

(b)(6)

NURSING UNIT ICU | ROOM NO. | BED NO. 12

24° ✓ Y-Int. Noted (b)(6)

PATIENT IDENTIFICATION

(b)(6)

166576

Noted 13 July 05 0100

DATE OF ORDER TIME

Vit C 500mg po qd

13 July 05 (b)(6)

Seen (b)(6) 13 July 2005 0900hrs

NURSING UNIT ICU | ROOM NO. | BED NO. 12

PATIENT IDENTIFICATION

Noted 14 July 05 0100

166579

DATE OF ORDER 13 Jul 05 TIME 1100

D/C Lasix

Make Colace prn

D/C Daily labs

Add CMP to labs drawn every Monday / Thursday

Noted (b)(6) 13 July 1115 hrs (b)(6)

NURSING UNIT ICU | ROOM NO. | BED NO. 12 24° Chart ✓ 14 July 05 (b)(6) 0100

FORM 3066-1, 19870401 (EF-V2) ...ATIENT RECORD

Exhibit 2

AC [redacted]

PATIENT IDENTIFICATION	DATE OF ORDER	TIME	NURSE'S SIGNATURE
1665786	14 JUL 05		
ATAWI Ahmed Ismail	Doxycycline 100mg po daily x 14 days		
	↑ Vitamin C to 500mg po bid ē meals		
	(b)(6)		(b)(6) 14 July 05
	Type + Cross for 2 units PRBC		
	Toradol 60 mg IM x 1 now		
	Transfuse 2 units PRBC when available	(b)(6)	(b)(6)
NURSING UNIT: ICW; ROOM NO.: ; BED NO.: 12	Re-med ē Tylenol 650mg and Benadryl 25 mg po		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME	NURSE'S SIGNATURE
Noted C 1900 (b)(6) 15 July 05	√ 24° Chart Check	(b)(6)	7/14/05
1665786	15 JUL 05		
Bed #12	BMP/CBC today, please	(b)(6)	
	Seen (b)(6)		
NURSING UNIT: ICW; ROOM NO.: ; BED NO.: 12	Chart √ 24° (b)(6)		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME	NURSE'S SIGNATURE
Noted C 2025 (b)(6) 15 July 05	20050715	2025	
1665786	Reglan 10 mg IM now		
	then		
	Reglan 10 mg IV TID PRN nausea		
	(b)(6)		
NURSING UNIT: ICW; ROOM NO.: ; BED NO.: 12	24° chart √ 16 July 05 (b)(6)		0103

PATIENT IDENTIFICATION	DATE OF ORDER	TIME	NURSE'S SIGNATURE
Noted C 1930 20 July 05 (b)(6)	20 JUL 05	1050	
1665786	Lasix 20mg po x Ī today		
	(b)(6)		(b)(6) 20 July 05 1100 hrs
NURSING UNIT: ICW; ROOM NO.: ; BED NO.: 12	24° chart √ 21 July 05 (b)(6)		

AF FORM 3066-1, 19870401 (EF-V2) INPATIENT RECORD

)C) 3 ORDERS - (SIGN ALL ORDERS)

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

For Each Set of Ord Reco Date and Time. Sign. and Cross Out Unused Lines

PATIENT IDENTIFICATION

166576

ATAWI Ahmed Ismail

NURSING UNIT ICW | ROOM NO. | BED NO. 12

DATE OF ORDER | TIME | NURSE'S SIGNATURE

NO:20 21Jul05 0355

Tylenol 650mg po q4° prn for pain

(b)(6)

(b)(6)

24 Chart / 21 July 05

(b)(6)

PATIENT IDENTIFICATION

DATE OF ORDER 21 Jul 05 TIME 1230

1) Quinine 650mg po TID

2) MOM/viscous lidocaine 15/15cc po q6° prn.

(b)(6)

(b)(6)

noted

July 21 05 1240hrs

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

166576

Bed #12

DATE OF ORDER 21 Jul 05 TIME 1330

1) Δ Quinine to mefloquine 750mg po x1 then give 500mg po 12 hrs later.

2) Morphine 4mg IM x1

noted

(b)(6)

(b)(6)

(b)(6)

21 July 05

Noted

UNIT ICW | ROOM NO. | BED NO. 12

24 Chart check for changes 7/21/05

PATIENT IDENTIFICATION

166576

Bed #12

Natural

22 July 05 1960

DATE OF ORDER | TIME

1) Lasix 40mg po x1

noted

22 July 05

1238hrs

(b)(6)

(b)(6)

(b)(6)

(b)(6)

ROOM NO. | BED NO. 12

24 Chart 22 July 05

(b)(6)

, 19870401 (EF-V2)

ACLU DDII CID ROIS 38897

000020

ACLU-RDI 5494 p.16

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

Exhibit 2

ician: (b)(6) Ward: [illegible] Bed: [illegible] Routine 27JUL03 1415hrs Initials: (b)(6) D&T: [illegible]

vn by

nistry (i-STAT) Syringe / Green Top
Gas - Bld Gas w/Lact - Glu - Crea

EST	RESULT	REF. RANGE
	7.160	7.35-7.45
O2	33.1	35-45 mmHg
2	202	80-100 mmHg
O2	13	18-33 mmol/L
:O3	11.8	22-26 mmol/L
2	99	95-99%
Eecf	-17	(-2) - (+3)
ctate		0.90-1.70 mmol/L
ucose		73-118 mg/dL
reat		0.6-1.3 mg/dL

Urinalysis

olor		Straw/Yellow
larity		Clear
ilucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 uIU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests:
(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer) Green Top
Chem 12 MetLyte8 BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN		7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL		98-109 mmol/L
TCO2		18-33 mmol/L
Creat		0.6-1.3 mg/dL
GGT		5-65 U/L
Glu		73-118 mg/dL
K		3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na		138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

(Coulter) Purple Top
CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/uL
RBC		4.2-6.1 x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential and Meningitis Panel (CSF only)

Exhibit 2

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

ICW

This form may be used for more than one day by ... or a new line for ongoing data. Insert column headings as required.

	PATIENT'S NAME	BP	PR	RR	T	UO	O2 SATURACT	LOC
12	166576	112/76	105	18	97.2	99	RA	Ø
July	166576 @ 1900	96/57	111	22	96.4	99	RA	Ø
JULY	2100	92/59	116	32	99°	99	RA	Ø
JULY	1400	92/50	106	17	994	98	RA	Ø
JULY	1900	91/56	108	20	98.1°	98	RA	Ø
5 July	1430	94/60	107	11	97.3	90	RA	Ø
06 JUL	1920	95/61	105	18	97.7	97	RA	Ø
July	1200hrs	98/65	119	14	982	96	RA	Ø
JULY	1900	88/52	114	22	98.4°	99	RA	Ø
8 July	1600	88/52	112	18	979	98	RA	Ø
9 July	1600	91/49	106	17	979	97	RA	Ø
9 JUL	1900	89/51	106	20	98.3	99	RA	Ø
10 Jul	1500	88/53	109	20	973	99	R/A	Ø
4	1900	84/52	105	20	97.6°	100	RA	Ø
11 July	1400	84/55	103	20	98.8	98	RA	Ø
11 JULY	1900	100/55	105	18	976	98	RA	Ø
12 JULY	1300	84/48	107	18	97.2	98	RA	Ø
12 JULY	1900	76/45	105	20	97.7	98	RA	Ø
13 July	1400	71/33	101	20	100.3		RA	Ø
13 July	1900	95/60	117	16	101.7 Axilary	98	RA	Ø
14 July	1100hrs	90/59	111	24	979	95	RA	Ø
14 July	1900	93/60	96	16	98.3°		RA	Ø
15 July	1500	98/52	101	16	-	96/0	RA	Ø
15 JULY	1900	98/61	104	18	99.2	94	RA	Ø
16		100/65	119		97			Ø

Exhibit 2

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

For use of this form, see AR 40-66; the proponent agency is the OTSG

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

WARD ICW I

DATE 2005 July 16

	PATIENT'S NAME	B/P	HR	RR	T	O2%	O2 SOURCE	PAIN
	166576							
16 July	1900	92/58	124	18	99.5	98	RA	Ø
17 July	1230	96/64	116	19	97.4	98	RA	Ø
17 July	1900	93/55	119	20	101.1	97	RA	Ø
17 July	2300				98.4			
18 July	1615hrs	95/56	116	14	98.2	98	RA	Ø
18 July	1900	97/63	121	18	99.3°		RA	Ø
19 July	1500hrs	96/58	118	18	99	98	RA	Ø
19 July	1900	108/53	96	20	98.3°	96	RA	Ø
20 July	1620hrs	116/65	102	22	99.5	99	RA	Ø
20 July	1900	99/61	119	18	98.3	95	RA	Ø
21 July		101/65	130	23	97.7	95	RA	Ø
21 July	1900	105/69	140	24	99.6	98	RA	Ø
22 July	16:30	99/62	108	24	98	96	RA	Ø
22 July	1900	98/66	122	24	98.4°	97	RA	Ø
11	2010	134/83	152	44				
11	2020	106/83	114	32				

ISN 166579

For your ind openion to imp.
the diagnosis by US with your
openion about managment with
best regardes.

* 30 years old patient complain of sevu pain in the abd. in below the left costa margin with low grade fever. normal bowel habit no diarhoea no constipation normal capethite with slight nausia.

CXS – ve
CUS – ve
UT – ve.
Drug history – ve.
Chronic Diseas – ve

* General Examination: Tired ill patient- Looks Lethargy & inability to walk due to Sudden hypotention.
* abdominal Examination: Superfacial Examination the abdomen is distended by inspection with slight elevation or Swalling above the area of Spleen. Supefacial palpation semi firm abdomin. deep palpation there is Spleenomegaly (the patient has ahistory of old Trauma to the site of spleen 4 month ago).
The spleen lenghth about 10–12 cm below the costal margin firm & tender.
* Vital Signes - BP :
  - Temp : Low grade fever
  - RR : 37
  - puls : 105

Deffrencial diagnosis : most likley go with
- Spleenomegaly.
- Haematoma

TASK FORCE MED 115 LABORATORY
Camp Bucca In...

LABORATORY FORM
(Subject to Privacy Act of 1974) 0073-05-CID579-40022

T, FIRST, MI. (Or Hospital ID #)	...e / Female	SSN or ISN: 166576	...nd Symptoms:
...sician: (b)(6) Ward: ICU 1	STAT	Specimen Collection Date & Time: 23JUL05 1630	Lab Use Only Initials (b)(6) / Lab Use Only D&T: 23JUL05/1635
...wn by: Bed:	Routine		

...mistry (i-STAT): Syringe / Green Top
...Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
	7.311	7.35-7.45
...O2	21.2	35-45 mmHg
...2	148	80-100 mmHg
...O2	11	18-33 mmol/L
...O3	10.7	22-26 mmol/L
...2	99	95-99%
...ecf	-16	(-2) - (+3)
...ctate		0.90-1.70 mmol/L
...ucose		73-118 mg/dL
...eat		0.6-1.3 mg/dL

Urinalysis

TEST	RESULT	REF. RANGE
...olor		Straw/Yellow
...arity		Clear
...ucose		Negative
...lirubin		Negative
...tone		Negative
...G		1.010-1.025
...ood		Negative
...H		5.0-8.0
...otein		Negative-Trace
...obili		0.1-1.0 Ehrlich U/dL
...trite		Negative
...uko		Negative

Urine Microscopic

...BC:	EPI:
...BC:	Mucus:
...acteria:	Yeast:
...asts:	Crystals:
...ther:	

...pecial Chemistries / Red or Tiger Top

TEST	RESULT	REF. RANGE
...SH		0.25 - 5 uIU/ml
...T4		9 - 20 pmol/L
...T3		4.0 - 8.3 pmol/L
...4		60 - 120 nmol/L
...3		0.92 - 2.33 nmol/L
...V		Negative

...dditional / Other Requests:
...onsult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top
Chem 12 MetLyte8 BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN		7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL		98-109 mmol/L
TCO2		18-33 mmol/L
Creat		0.6-1.3 mg/dL
GGT		5-65 U/L
Glu		73-118 mg/dL
K		3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na		138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

TEST	RESULT	REF. RANGE
Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top
CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/uL
RBC		4.2-6.1 x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

TEST	RESULT	REF. RANGE
Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

TEST	RESULT	REF. RANGE
Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

TEST	RESULT	REF. RANGE
Hb S		Negative

Coagulation / Blue Top (3.2%)

TEST	RESULT	REF. RANGE
PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

TEST	RESULT	REF. RANGE
Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

ACLU DDII CID ROIS 38903

000026

Physician: (b)(6) | Ward: | Bed: SCM | Female | Routine | Specimen Collection Date & Time: 24JUL05 1665 IL | Lab Use Only Initials: (b)(6) | 0073-05-CID579-40022 | Lab Use Only D&T: 1245

Chemistry (i-STAT) Syringe / Green Top
Blood Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
	6.956	7.35-7.45
CO2	82.0	35-45 mmHg
O2	69	80-100 mmHg
HCO2	21	18-33 mmol/L
HCO3	18.3	22-26 mmol/L
O2	78	95-99%
Base ecf	-14	(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

RBC:	EPI:
WBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 uIU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
B1		60 - 120 nmol/L
B6		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests:
(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top
Chem 12 Met/Lyte8 bMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN		7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL		98-109 mmol/L
TCO2		18-33 mmol/L
Creat		0.6-1.3 mg/dL
GGT		5-65 U/L
Glu		73-118 mg/dL
K		3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na		138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top
CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/uL
RBC		4.2-6.1 x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container
Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

ST, FIRST, MI. (Or Hospital ID #) | X ale / Female | SSN or ISN: [redacted]4524 | Signs and Symptoms:

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE 0073-05-CID579-40022

sician (b)(6) | Ward: 3gen1 | Bed: | X STAT / Routine | Specimen Collection Date & Time: 24 Jul 05 1400 hrs | Lab Use Only Initials: (b)(6) | Lab Use Only D&T: 24JUL05 1400

Urinalysis (I-STAT): Syringe / Green Top — Gas: Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
	7.179	7.35-7.45
CO2	45.2	35-45 mmHg
O2	101	80-100 mmHg
HCO2	18	18-33 mmol/L
CO3	16.8	22-26 mmol/L
2	96	95-99%
ecf	-12	(-2) - (+3)
ctate		0.90-1.70 mmol/L
ucose		73-118 mg/dL
eat		0.6-1.3 mg/dL

Urinalysis

lor		Straw/Yellow
arity		Clear
ucose		Negative
lirubin		Negative
tone		Negative
G		1.010-1.025
ood		Negative
H		5.0-8.0
otein		Negative-Trace
obili		0.1-1.0 Ehrlich U/dL
trite		Negative
uko		Negative

Urine Microscopic

BC:		EPI:	
BC:		Mucus:	
acteria:		Yeast:	
asts:		Crystals:	
ther:			

Special Chemistries / Red or Tiger Top

SH		0.25 - 5 ulU/ml
T4		9 - 20 pmol/L
T3		4.0 - 8.3 pmol/L
		60 - 120 nmol/L
B		0.92 - 2.33 nmol/L
IV		Negative

Additional / Other Requests: (Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top — Chem 12 Met Lyte8 BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN		7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL		98-109 mmol/L
TCO2		18-33 mmol/L
Creat		0.6-1.3 mg/dL
GGT		5-65 U/L
Glu		73-118 mg/dL
K		3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na		138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top — CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/uL
RBC		4.2-6.1 x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

Ac 14/600/100

ACLU DDII CID ROIS 38905

ACLU-RDI 5494 p.24

000028

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

Exhibit 2

Physician (b)(6) Ward: ICU [ ] STAT Specimen Collection Date & Time: Initials: (b)(6) D&T: 28 Jan 05 2025

Drawn by [illegible] [ ] Routine 28 Jan 05 0600

Chemistry (i-STAT) Syringe / Green Top

Bld Gas Bld Gas w/Lact Glu Crea

TEST	RESULT	REF. RANGE
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 ulU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests (Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer) Green Top

Chem 12 MetLyte8 BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB	21.0 L	3.3-5.5 g/dL
ALP	162 H	26-184 U/L
ALT	122 H	10-47 U/L
AMY	7 L	14-110 U/L
AST	387 H	11-38 U/L
Tbil	0.5	0.2-1.6 mg/dL
BUN	25 H	7-22 mg/dL
Ca	7.3 L	8.0-10.3 mg/dL
Chol	73 L	100-200 mg/dL
CK	425 H	M: 39-380 U/L
		F: 30-190 U/L
CL	90 L	98-109 mmol/L
TCO2	17 L	18-33 mmol/L
Creat	1.3 H	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	169 H	73-118 mg/dL
K	5.7 H	3.3-4.9 mmol/L
TProtein	3.8 L	6.4-8.1 g/dL
Na	125 L	138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter) Purple Top

CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC	14.6	4.8-10.8 x10(3)/uL
RBC	3.97	4.2-6.1 x10(6)/uL
Hgb	9.3	12.0-18.0 g/dL
Hct	30.0	M: 42.0-52.0%
		F: 37-47%
MCV	75.6	80.0-99.0 fl
MCH	23.4	27.0-31.0 pg
MCHC	31.0	33.0-37.0 g/dL
Plt	495	130-400 x10(3)/uL
LY%	13.4	20.0-44.0%
LY#	2.0	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential and Meningitis Panel (CSF only)

ICU Bed 1

166576

ATAUL AHMED 000029 ISMAIL 2

Exhibit 2

ST, FIRST, MI: (Of Hospital ID #) | Male / Female | Collection Date & Time: 166/16

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

0073-05-CID579-40022

Physician (b)(6) | Ward: 4th | Bed: 1 | Routine | Specimen Collection Date & Time: 24JUL05 1630 HRS | Initials: (b)(6) | Lab Use Only D&T: 24JUL05 1640

Blood Gas (i-STAT) Syringe / Green Top

Blood Gas - Bld Gas w/Lact Glu Crea

TEST	RESULT	REF. RANGE
	7.290	7.35-7.45
O2	30.0	35-45 mmHg
)2	62	80-100 mmHg
O2		18-33 mmol/L
CO3	14.4	22-26 mmol/L
2	89%	95-99%
ecf	-12	(-2) - (+3)
ctate		0.90-1.70 mmol/L
ucose		73-118 mg/dL
eat		0.6-1.3 mg/dL

Urinalysis

lor		Straw/Yellow
arity		Clear
ucose		Negative
lirubin		Negative
tone		Negative
		1.010-1.025
ood		Negative
		5.0-8.0
otein		Negative-Trace
obili		0.1-1.0 Ehrlich U/dL
trite		Negative
uko		Negative

Urine Microscopic

BC:	EPI:
BC:	Mucus:
acteria:	Yeast:
asts:	Crystals:
ther:	

Special Chemistries / Red or Tiger Top

SH		0.25 - 5 uIU/ml
T4		9 - 20 pmol/L
T3		4.0 - 8.3 pmol/L
		60 - 120 nmol/L
		0.92 - 2.33 nmol/L
V		Negative

Additional / Other Requests (Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top

Chem 12 Met Lyte BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN		7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL		98-109 mmol/L
TCO2		18-33 mmol/L
Creat		0.6-1.3 mg/dL
GGT		5-65 U/L
Glu		73-118 mg/dL
K		3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na		138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top

CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/uL
RBC		4.2-6.1 x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

AC14/600/100

ACLU DDII CID ROIS 38907

000030

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

Exhibit 2

TASK FORCE MED 115 LABORATORY — LABORATORY FORM
Camp Bucca Iraq — FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE — DoD 1974.03-05-CID179-40022

ST, FIRST, MI. (Or Hospital ID #)

sician: (b)(6) Ward: ICW

wn by: (b)(6) Bed: #12

SSN or ISN: 16576

Male / Female

STAT / Routine

Specimen Collection Date & Time: 23 July 0950

Signs and Symptoms: MALARIA

Lab Use Initials: (b)(6)

Lab Use Only D&T: 23 July 05 1020

mistry (i-STAT) Syringe / Green Top

1 Gas, Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH	7.262	7.35-7.45
pO2	27.5	35-45 mmHg
pO2	161	80-100 mmHg
cO2	13	18-33 mmol/L
cHCO3	12.4	22-26 mmol/L
sO2	99	95-99%
Base ecf	-15	(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 ulU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
[illegible]		60 - 120 nmol/L
[illegible]		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests:

(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer) Green Top

Chem 12 / Metlyte8 / BMP / Liver / Lipid / Renal

TEST	RESULT	REF. RANGE
ALB	<1.0	3.3-5.5 g/dL
ALP	154	26-184 U/L
ALT	41	10-47 U/L
AMY	10	14-110 U/L
AST	103	11-38 U/L
Tbil	0.3	0.2-1.6 mg/dL
BUN	18	7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK	144	M: 39-380 U/L
		F: 30-190 U/L
CL	92	98-109 mmol/L
TCO2	14	18-33 mmol/L
Creat	1.5	0.6-1.3 mg/dL
GGT	22	5-65 U/L
Glu	48	73-118 mg/dL
K	5.3	3.3-4.9 mmol/L
TProtein	3.7	6.4-8.1 g/dL
Na	130	138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter) Purple Top

CBC / Manual Differential

TEST	RESULT	REF. RANGE
WBC	13.3	4.8-10.8 x10(3)/uL
RBC	4.40	4.2-6.1 x10(6)/uL
Hgb	10.0	12.0-18.0 g/dL
Hct	32.6	M: 42.0-52.0%
		F: 37-47%
MCV	74.2	80.0-99.0 fl
MCH	22.8	27.0-31.0 pg
MCHC	30.8	33.0-37.0 g/dL
Plt	541	130-400 x10(3)/uL
LY%	33.6	20.0-44.0%
LY#	4.5	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph: 3+ hypo, 2+ anisocy, 1+ tear, 2+ micro, 2+ crenated, 2+ burr, 1+ ovalo

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT	30.4	7.0-14.0 sec
APTT	41.2	21.0-50.0 sec
INR	3.0	0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin	3.9	NEG / 0-107 ng/mL
CK-MB 3.4	7500	NEG / 0-4.3 ng/mL
Troponin	<0.04	NEG / 0.0-0.4 ng/mL

7500

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

Physician: (b)(6) | Ward: ICU | STAT | Specimen Collection Date & Time: 24/1405 1800 | (b)(6) | D&T: 24/1406 | 184

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

Drawn by

Chemistry (i-STAT) / Syringe / Green Top

Bld Gas | Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH	7.341	7.35-7.45
PCO2	27.7	35-45 mmHg
PO2	76	80-100 mmHg
TCO2	16	18-33 mmol/L
HCO3	15.0	22-26 mmol/L
sO2	94	95-99%
BEecf	-11	(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 ulU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests:
(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top

Chem 12 | MetLyte8 | BMP | Liver | Lipid | Renal

TEST	RESULT	REF. RANGE
ALB	21.0	3.3-5.5 g/dL
ALP	162	26-184 U/L
ALT	117	10-47 U/L
AMY	17	14-110 U/L
AST	275	11-38 U/L
Tbil	0.5	0.2-1.6 mg/dL
BUN	25	7-22 mg/dL
Ca	6.8	8.0-10.3 mg/dL
Chol	55	100-200 mg/dL
CK	325	M: 39-380 U/L
		F: 30-190 U/L
CL	93	98-109 mmol/L
TCO2	15	18-33 mmol/L
Creat	1.4	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	146	73-118 mg/dL
K	5.0	3.3-4.9 mmol/L
TProtein	3.7	6.4-8.1 g/dL
Na	124	138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top

CBC | Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/uL
RBC		4.2-6.1 x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential and Meningitis Panel (CSF only)

160526

ATAWI, AHMED

1663 1C

Female

0053-05-CID579-40022

Physician: (b)(6) | Ward: SCU | STAT | Specimen Collection Date & Time: 25 JUL 05 0735 hrs | Initials: (b)(6) | Lab Use Only
Drawn by | Bed: 1 | Routine | | | D&T: 25 July 05 0842

Chemistry (I-STAT): Syringe / Green Top
Bld Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH	7.371	7.35-7.45
PCO2	28.4	35-45 mmHg
PO2	130	80-100 mmHg
TCO2	17	18-33 mmol/L
HCO3	16.4	22-26 mmol/L
sO2	99	95-99%
BEecf	-9	(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Chemistry (Piccolo Analyzer): Green Top
Chem 12 (MetLyte8) BMP (Liver) Lipid (Renal)

TEST	RESULT	REF. RANGE
ALB	2.0	3.3-5.5 g/dL
ALP	185	26-184 U/L
ALT	127	10-47 U/L
AMY	10	14-110 U/L
AST	220	11-38 U/L
Tbil	0.6	0.2-1.6 mg/dL
BUN	28	7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK	261	M: 39-380 U/L
		F: 30-190 U/L
CL	93	98-109 mmol/L
TCO2	17	18-33 mmol/L
Creat	1.1	0.6-1.3 mg/dL
GGT	33	5-65 U/L
Glu	107	73-118 mg/dL
K	5.2	3.3-4.9 mmol/L
TProtein	3.6	6.4-8.1 g/dL
Na	126	138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Hematology (Coulter): Purple Top
(CBC) Manual Differential

TEST	RESULT	REF. RANGE
WBC	9.6	4.8-10.8 x10(3)/uL
RBC	3.42	4.2-6.1 x10(6)/uL
Hgb	7.9	12.0-18.0 g/dL
Hct	24.7	M: 42.0-52.0%
		F: 37-47%
MCV	72.3	80.0-99.0 fl
MCH	23.0	27.0-31.0 pg
MCHC	31.8	33.0-37.0 g/dL
Plt	492	130-400 x10(3)/uL
LY%	18.5	20.0-44.0%
LY#	1.8	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph: 2+ hypo, 2+ microcytic, 2+ aniso, 1+ teardrop, 1+ oval

Plt Abn Morph:

WBC Abn Morph:

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 uIU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests
(Consult with Lab Prior to Submitting)

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container
Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential and Meningitis Panel (CSF only)

ACLU DDII CID ROIS 38910
000033

ACLU-RDI 5494 p.29

Exhibit 2

TASK FORCE MED TIG LABORATORY — LABORATORY FORM

Camp Bucca Internment Facility SASH, Iraq — (Subject to Privacy Act of 1974) [illegible]579-40022

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

LAST, FIRST, MI. (Or Hospital ID #)	Male	SSN or ISN: 166576	Signs and Symptoms:
	Female		
Physician: (b)(6) Ward: ICU	STAT	Specimen Collection Date & Time:	Lab Use Only Initials (b)(6) / Lab Use Only D&T: 26 July 05
Drawn by: Bed: 1	Routine	26 July 05 0600	

Chemistry (i-STAT): Syringe / Green Top
Bld Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH	7.439	7.35-7.45
PCO2	22.5	35-45 mmHg
PO2	117	80-100 mmHg
TCO2	16	18-33 mmol/L
HCO3	15.3	22-26 mmol/L
sO2	99	95-99%
BEecf	-9	(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

TEST	RESULT	REF. RANGE
Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TEST	RESULT	REF. RANGE
TSH		0.25 - 5 uIU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests
(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top
Chem 12 MetLyte8 BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN		7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL		98-109 mmol/L
TCO2		18-33 mmol/L
Creat		0.6-1.3 mg/dL
GGT		5-65 U/L
Glu		73-118 mg/dL
K		3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na		138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

TEST	RESULT	REF. RANGE
Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top
CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/uL
RBC		4.2-6.1 x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

TEST	RESULT	REF. RANGE
Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

TEST	RESULT	REF. RANGE
Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

TEST	RESULT	REF. RANGE
Hb S		Negative

Coagulation / Blue Top (3.2%)

TEST	RESULT	REF. RANGE
PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

TEST	RESULT	REF. RANGE
Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

ACLU DDII CID ROIS 38911

000034

ACLU-RDI 5494 p.30

Exhibit 2

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

Female 168449

FOR OFFICIAL USE ONLY/LAW ENFORCEMENT SENSITIVE

0073-05-CIDS79-40022

ysician: (b)(6) | Ward: ICU | Bed: 4 | Routine | Specimen Collection Date & Time: Blood 20JUL05 0600hrs | Lab Use Only D&T: 0652

Chemistry (i-STAT) Syringe / Green Top
Bld Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
H		7.35-7.45
CO2		35-45 mmHg
O2		80-100 mmHg
CO2		18-33 mmol/L
CO3		22-26 mmol/L
O2		95-99%
Eecf		(-2) - (+3)
actate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 uIU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests:
(Consult with Lab Prior to Submitting)

FOR SHIPOUTS, FILL OUT CONSULTATION FORM.

Chemistry (Piccolo Analyzer): Green Top
Chem 12 MetLyte BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB	3.4	3.3-5.5 g/dL
ALP	76	26-184 U/L
ALT	23	10-47 U/L
AMY	56	14-110 U/L
AST	22	11-38 U/L
Tbil	0.9	0.2-1.6 mg/dL
BUN	32	7-22 mg/dL
Ca	8.9	8.0-10.3 mg/dL
Chol	207	100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL		98-109 mmol/L
TCO2		18-33 mmol/L
Creat	1.1	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	115	73-118 mg/dL
K		3.3-4.9 mmol/L
TProtein	6.9	6.4-8.1 g/dL
Na		138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top
CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/uL
RBC		4.2-6.1 x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells
RBC Abn Morph:	
Plt Abn Morph:	
WBC Abn Morph:	

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

166576

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

Female

Specimen Collection Date/Time: 27 Jul 05 @ 0600

Routine

Ward: [redacted]

Bed: 1

Lab Use Only

Init:

Lab Use Only

D&T:

Chemistry (i-STAT) Syringe / Green Top

Bld Gas w/Lact Glu - Crea

TEST	RESULT	REF. RANGE
	7.347	7.35-7.45
CO2	22.2	35-45 mmHg
O2	97	80-100 mmHg
CO2	13.0	18-33 mmol/L
CO3	12.2	22-26 mmol/L
O2	97	95-99%
Eecf	-13	(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 uIU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests (Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer) Green Top

Chem 12 MetLyte BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN	42	7-22 mg/dL
Ca	6.0	8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK	624 H	M: 39-380 U/L
		F: 30-190 U/L
CL	101	98-109 mmol/L
TCO2	18	18-33 mmol/L
Creat	2.7	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	73	73-118 mg/dL
K	5.4	3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na	129	138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter) Purple Top

CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC	23.6 H	4.8-10.8 x10(3)/uL
RBC	3.31 L	4.2-6.1 x10(6)/uL
Hgb	8.1 L	12.0-18.0 g/dL
Hct	25.5 L	M: 42.0-52.0%
		F: 37-47%
MCV	78.2	80.0-99.0 fl
MCH	24.6	27.0-31.0 pg
MCHC	31.4	33.0-37.0 g/dL
Plt	356	130-400 x10(3)/uL
LY%	9.2	20.0-44.0%
LY#	2.2	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential and Meningitis Panel (CSF only)

166576

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

Lab Use Only D&T:

Physician: (b)(6) Ward: TCC Bed: 1

Drawn by: Routine Specimen Collection Date & Time: 26 JUL 05 0600

Chemistry (i-STAT): Syringe / Green Top

Chem 8 Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
~~E87~~	7.439	7.35-7.45
pCO2	22.5	35-45 mmHg
pO2	117	80-100 mmHg
tCO2	16	18-33 mmol/L
HCO3	15.3	22-26 mmol/L
sO2	99	95-99%
BEecf	-9	(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Chemistry (Piccolo Analyzer): Green Top

Chem 12 Electrolytes BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN	33	7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK	320	M: 39-380 U/L
		F: 30-190 U/L
CL	93	98-109 mmol/L
TCO2	19	18-33 mmol/L
Creat	1.3	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	89	73-118 mg/dL
K	5.4	3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na	132	138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Hematology (Coulter): Purple Top

CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC	23.3	4.8-10.8 x10(3)/uL
RBC	3.37	4.2-6.1 x10(6)/uL
Hgb	9.0	12.0-18.0 g/dL
Hct	25.9	M: 42.0-52.0%
		F: 37-47%
MCV	76.9	80.0-99.0 fl
MCH	26.7	27.0-31.0 pg
MCHC	34.7	33.0-37.0 g/dL
Plt	452	130-400 x10(3)/uL
LY%	5.4	20.0-44.0%
LY#	1.3	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 uIU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests (Consult with Lab Prior to Submitting)

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Malaria Smear / Purple Top

Thin	Pos	No Plasmodium Seen
Thick	Pos	No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential and Meningitis Panel (CSF only)

DOCTOR'S ORDERS - *(SIGN ALL ORDERS)*

For Each Set of Orders. Record the Date and Time. Sign. and Cross Out the Unused Lines

PATIENT IDENTIFICATION
166576
Atawi, Ahmed Ismail
ICU Bed 1

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 23 Jul 05 TIME 1330 NURSE'S SIGNATURE

↑ Ir NS @ 999 c/h.

Verbal order (b)(6)

(b)(6)

PATIENT IDENTIFICATION
166576
Atawi, Ahmed Ismail
ICU Bed 1

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 23 Jul 05 TIME 1430

Infuse 250cc bag of 5% albumin @ 100cc/hr then Resume NS @ 150cc/hr (b)(6)

1435 No albumin available in stock

Continue NS (b)(6)

PATIENT IDENTIFICATION
166576
Atawi, Ahmed Ismail
ICU Bed 1

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 23 Jul 05 TIME 1515

1) ABCs,
2) KUB upright
3) Dilute 25% albumin in 500cc NS then infuse @ 100cc/hr
4) Ceftriaxone 1gm IVP.

Noted Jul 23, 2005 @ 1800 (b)(6) (b)(6)

PATIENT IDENTIFICATION
166576
Atawi, Ahmed Ismail
ICU Bed 1

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 23 Jul 05 TIME 1760

Fingerstick glucose if initial >100 qac
2 successive shifts - then q 4°
D5 1/2 NS @ 100 cc/hr
D50 1 Amp now
Repeat Rocephin 1 gm now
then
NPO to continue order
Repeat KUB in 5 days

(b)(6) 2450 of 1925 hrs (b)(6)

UNIT | ROOM NO | BED NO

DOCTOR'S ORDERS - *(SIGN ALL ORDERS)*

For Each Set of Orders, Record the Date and Time, Sign, and Cross Out the Unused Lines

PATIENT IDENTIFICATION

Atawi Ahmed Ismail

166576

ICU 1

DATE OF ORDER | TIME | NURSE'S SIGNATURE

Verbal order (b)(6)

Give Dext 50% 1 amp IVP if glucose < 70 (b)(6)

Relan to 10m IV Q4° prn KA

TVF - DS ½ NS @150/hr KA

2225 HRS (b)(6)

NURSING UNIT | ROOM NO. | BED NO. (b)(6)

PATIENT IDENTIFICATION

DATE OF ORDER 24 July 05 TIME 730

Infuse 250cc 5% albumin @ 100cc/hr

Then resume N.S. @ 150cc/hr (b)(6)

noted July 24, 2005 @ 0800 hrs (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 24 Jul 05 TIME 1030

Resume D5 NS (or D5LR) @ Albumin is in at 150cc/hr (b)(6)

Give D50 1 Amp now

Cancel NS order above

KUB

Ceftriaxone 1 gm IV q24° (b)(6)

Noted 24 Jul 05 @ 1100h

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 24 JUL 05 TIME 1215

Dopamine 2 mcg/kg/min drip - start now (b)(6)

(b)(6) 24 JUL 05 1925 hrs

noted 24 Jul @ 1230 hrs (b)(6)

NURSING UNIT | ROOM NO | BED NO

ACLU D[illegible]OIS 38916

DOCTOR'S ORDERS - (SIGN ALL ORDERS)

For Each Set of Orders. Record the Date and Time. Sign. and Cross Out the Unused Lines

PATIENT IDENTIFICATION: Atawi, Ahmed Ismail 166576

DATE OF ORDER 24 JUL 05 TIME 1415 NURSE'S SIGNATURE

- ↑ Dopamine to 10 mcg/kg/min
- Diprivan @ 10 mcg/kg/min → 3cc/hr and titrate for sedation
- Add 2 Amps bicarb to IVF (current maintenance bag)

noted 24 Jul 05 @ 1420 hrs (b)(6)

NURSING UNIT ICU ROOM NO. BED NO. 1

PATIENT IDENTIFICATION

DATE OF ORDER 24 Jul 05 TIME 1520

- Vent settings - IMV 14 Tidal volume 600 noted 24 Jul 05 1520 (b)(6)
- FIO2 100 %
- ABG in 1 hour.

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 24 Jul 05 TIME 1705

- Δ TV to 700
- PEEP 5
- ABG in 1 hour Repeat BMP at 1730 hrs
- Zantac IVP 50 mg q 6 hours
- Lasix 40 mg IVP x 1

noted 24 Jul 05 1730 hrs (b)(6)

(b)(6) 24 JUL 05 1920 hrs

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 25 Jul 05 TIME 0845

- D/C Diprivan
- Begin Ativan Infusion 1-2 mg/hr to keep Pedation - Put in 250 NS
- ↓ D5LR to 50cc/hr
- Lasix 20mg IVP
- Bed trans q2hrs
- CXR to verify line placement - done by (b)(6)
- ↓ FIO2 to 70%
- AM labs: CBC, chem 8, ABG's, AM CXR

(b)(6) 25 JUL 05 1930 hrs

NURSING UNIT ROOM NO BED NO

DOCTOR'S ORDERS - *(SIGN ALL ORDERS)*

For Each Set of Orders: Record the Date and Time. Sign. and Cross Out the Unused Lines

PATIENT IDENTIFICATION
Atawi, Ahmed Ismail
1665726

NURSING UNIT ICU | ROOM NO. | BED NO.

DATE OF ORDER 25 Jul 05 TIME 1600 NURSE'S SIGNATURE

1) Switch Dopamine to norepinephrine drip. Start at 10mcg per minute and titrate to keep SBP ≥ 80

2) Begin Flagyl 500mg IV q8°

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 25 JUL 05 TIME

Repeat Hct and Fibrinogen in AM

(b)(6)

(b)(6)

7/25/05 1930hrs

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 26 Jul 05 TIME 0900

1) Lasix 40mg IV q12hrs
2) Change Zantac to 50 mg IV q12°
3) Am labs: CBC, Chem 8, ABG.
4) 8mg levophed in 250cc NS. Titrate infusion to keep SBP ≥ 90

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER TIME

(b)(6)

7/26/05 1930hrs

ACLU DDII CID ROIS 38918
000041

DOCTOR'S ORDERS - *(SIGN ALL ORDERS)*

For Each Set of Orders. Record the Date and Time. Sign. and Cross Out the Unused Lines

PATIENT IDENTIFICATION

#166576 Ismail
Atawi, Ahmed ~~Abood~~

NURSING UNIT	ROOM NO.	BED NO.
ICU	i	

DATE OF ORDER	TIME	NURSE'S SIGNATURE

PATIENT IDENTIFICATION

166576 Ismail
Atawi, Ahmed ~~Abood~~

NURSING UNIT	ROOM NO.	BED NO.
ICU	i	

DATE OF ORDER	TIME

PATIENT IDENTIFICATION

166576
Atawi, Ahmed Ismail

NURSING UNIT	ROOM NO.	BED NO.
ICU	i	

DATE OF ORDER	TIME

PATIENT IDENTIFICATION

#166576
Atawi, Ahmed Ismail

NURSING UNIT	ROOM NO	BED NO

DATE OF ORDER	TIME

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

For use of this form, see AR 40-66; the proponent agency is the OTSG

WARD ~~ICU~~ ICU bed 1

DATE 23 Jul 05

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

	PATIENT'S NAME	B/P	HR	RR	T	O2%	O2 SOURCE	PAIN
0955	#165576 Atawi, Ahmed Ismail	~~88~~/48	102	45			100% NR	
1000		80/41	101	38			100% NR	
1020		82/54	104	34	91.8		100% NR	
1100		78/53	106	35		100%	RBBM	ϕ
1130		77/53	109	31		100%	Non rebreather	
1200		79/54	110	34		100%	2L NC	ϕ
1230		77/53	118	34	93.6	98	2L NC	ϕ
1300	—	77/55	119	37	94.4	96%	2L NC	ϕ
1330		81/54	117	38	94.6	98%	2L NC	ϕ
1400		91/60	119	~~36~~ ~~43~~	93.4	100%	2L NC	ϕ
1430		82/56	121	43		100	2L NC	ϕ
1614		80/52	121	47	~~92.1~~	~~unable to detect~~ 92%	100% non rebreather	ϕ
1630	↑ D5½NS, Alb 25% D5W 500mls.	88/52	117	40				
	1640 ↑ Rocephin 50ml							
1700		76/59	117	48				
1730		89/56	117	48	91.7			
1800		106/90	119	44		92%	100% NRB	ϕ
1830	Turn (L) side	86/51	113	54		98%	"	
1900		86/47	113	45 ~~50~~		95%	"	
1930	Turn (R) side	94/64	114	44		93%	4L NC	ϕ
2000		87/40	113	42	93.1	96%	100% NRB	ϕ
2030		98/34	117	42		97%	100% NRB	ϕ
2100		87/53	118	36		98	100% NRB	ϕ
2130		82/49	117	34		98	100% NRB	ϕ
2300		88/55	125	35		94	4L NC	ϕ

52 48 63 (b)(6)

Exhibit 2

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

For use of this form, see AR 40-66; the proponent agency is the OTSG

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

WARD ICU BED #1

DATE 24TH JULY 2005

PATIENT'S NAME ISN: 166576, ATAWI, AHMED ISMAIL

		B/P	HR	RR	T	O2%	O2 SOURCE	PAIN
2400		87/55	123	39	93¹	95%	6L NC	Ø
0100		85/55	123	46		90%	6L NC	Ø
0200		82/50	122	43		98%	6L NC	Ø
0280		85/58	127	31		96%	6L NC	Ø
0300		96/55	126	38		94%	6L NC	Ø
0400		92/50	119	40		95%	6L NC	Ø
0500		99/55	119	38	94°	93	6L NC	Ø
0600		92/58	117	31		93	6L NC	Ø
0700		79/41	113	38		93	6L NC	Ø
0730		81/48	112	57		83	6L NRB	Ø
0800	Out to ED.	79/49	112	55	92³	76	6L NRB	Ø
0900	TS=110 NG 85cc	81/47 (MA)	110	48	100@	100@	10 NRB	Ø
0930	urine 30cc	81/55	111	55		100@	10 NRB	
1000	urine 15cc	MA 76	111	50		100@	10 NRB	
1030		92/47	105	50		100@	10 NRB	
1100	urine 10cc	83/48	112	42	94²		10 NRB	Ø
1200	urine=10cc	74/48	96	38	92⁴		8L NRB	
1300		221/174	95	24			Bipap hyperventilate	
1305		198/154	101					
1308	Intubated @ 1308	54 palp						
1317	7.5 ETT @ 22 cm	67/33	102	18				
1325	@ lip	86/39	101	14				
1328		90/34						
1420		89/57		23				

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

For use of this form, see AR 40-66; the proponent agency is the OTSG

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

WARD ~~ICW~~ ICU Bed 1

DATE 24 Jul 05

PATIENT'S NAME 1660576 ATTAWI, Ahmed Ismael

		B/P	HR	RR	T	O2%	O2 SOURCE	PAIN
1500	ETT 7.5 mm 22cm@lip	103/69	113	34				
1600	↑ Diprivan @1610 to 5cc	105/76	112	38		62	Ventilator	
1700		112/80	115	28		97	"	
1800		99/67	108	33				
1900		111/63	104	19		94		
2000		113/63	115	14		98%		

Exhibit 2

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

For use of this form, see AR 40-66; the proponent agency is the OTSG

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

WARD ~~ICW~~ ICU Bed 1

DATE 25 Jul 05

PATIENT'S NAME		CVP	Hourly Urine Output	B/P	HR	RR	T	O2%	O2 SOURCE	PAIN
25Jul05	0700			65/44	127	28	97.8(a)	95	Vent	Ø
~	0730			82/42	130	30		95	Vent	
~	0800 Right side			81/55	136	31		95	Vent	
~	0830			85/47	133	30		95	Vent	
~	0900			76/42	130	32		95	Vent	
~	0930	19	60cc	76/44	128	40		92	Vent	
~	1000 Left side	19		79/57	134	35		90	Vent	
~	1030	21		78/48	131	43		95%	Vent	
	1100	22		113/33	136	41		95	Vent	
	1130	22		73/46	126	40		95%	Vent	
	1200 Right side	26	60cc	94/55	133	25	97.8(a)	94	Vent	
	1230	20		91/59	131	23		100%	Vent	
	1300	16	0	96/64	134	36	98.1			
	1330	17		84/47	134	31				
	1400	8	Ø	65/28	128	41				
	1430	13		74/23	130	30		94%	Vent	
	1500	15	60cc	71/46	135	52	98.1	99	Vent	
	1600	15	Ø	75/44	136	41		100	Vent	
	1700	13		77/33	136	44		99	Vent	
	1730	13	↑ dopam to 8.4mg	66/32	139	48		99		
	1752	14		68/42	141	44		99		
	1753	15		70/39	141	44		99		
	1800	13		76/42	144	43		98		
	1830	18		85/44	142	53		96		

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS
For use of this form, see AR 40-66; the proponent agency is the OTSG

WARD ~~ICU~~ ICU Bed 1

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

DATE 25 JUL 05

	PATIENT'S NAME	B/P	HR	RR	T	O2%	~~O2~~ SOURCE	~~PAIN~~ Levo
1200 hrs	Atawi, Ahmed Ismail	73/43	145	20/14	99.5 (A)	97%	13	↑ to 15 mcg/min
0000 hrs	166576	75/35	139	22/14		99%		↑ to 20 mcg/min
0100 hrs		79/42	139	20/14		100%		20 mcg/min
0200		78/44	139	20/14		100%		20 mcg/min
0300		71/38	139	20/14		100%		↑ 25 mcg/min
0400		80/48	136	18/14		100%	14	25 mcg/min
0100		77/47	140	20/14		100%		25 mcg/min
0200		81/47	141	22/14	100.0 (A)	100%		25 mcg/min
0300		83/46	140	20/14		100%		25 mcg/min
0400		81/48	136	20/14		100%		25 mcg/min A+
0500		83/47	137	22/14		100%		25 mcg/min ↓
0600		79/50	138	20/14		100%	14	25 mcg/min A+ ↑
0700		82/44	137	23/6	100.3	99%	20	25 mcg/min
0800		84/45	136	24/2		99	12	25 mcg/min

Task Force 344 Ventilator Flow Sheet

Patient Info: Name: 166576
Age: _____ DOB: _____
Gender: M Pt. ID: _____

Date: 25 JUN 05
Vent Day #: 2
Vent Unit #: 5017

		0725	0815	1040	1300	1655	1815	1912	2250	2100	0400					
	Time															
	Mode	AC		AC	AC	AC	AC	AC	A/C	A/C	A/C					
Rate	Set	14		14	14	14	14	14	14	14	14					
	Spont	/		/			/	—	—	—	—					
	Total	15		15				—	—	—	40					
Vt	Set	700		700	700	700	700	700	700	700	700					
	Spont	—						—	—	—	—					
	MV	10.4		10.5	10.4	10.4	10.6	9.9	9.9	9.9	9.8					
	FiO2	100%	85	70	50	40	40%	40%	40%	40%	40%					
	Peep	5		5	5	5	5	5	5	5	5					
	I/E	1:2.0		1:2	1:2	1:2	1:2	1:2	1:2	1:2	1:2					
	Flow	—		—				—	60	60	60					
	Sens	—		—				—	2.0	2.0	2.0					
	PIP	39		34	31	38	36	34	33	34	38					
	MAP	9		8	10	11	7	17	16	15	17					
	Sats			100			96	97	99	100	100					
	PIP Alarm Hi/LO	50/10	/	50/10	50/10	50/10	50/10	60/10	60/10	60/10	60/10					
	Initials	(b)(6)														

ETT/Trach

Size	Position	Cuff
7.5	22	mop
7.5	22	mop

0725 - Cyl. press - 900
1040 ——→ 1600 PSI
1451 ——→ 1100 PSI
1900 ——→ New Cyl. 2200 PSI
2250 ——→ 1800 PSI
0638 ——→ 1000 PSI

ABG

Hgb 16.4

Time	PH	PCO2	PO2	TCO2	BE
1730	7.37	36.4	130	17	-9

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

Task Force 344 Ventilator Flow Sheet
Respiratory Notes

7a-7p

Received pt. on 754 Impact Vent. Remained intubated orally c 7.5 ETT. BSS equal bilat. ABG drawn in am + results pending. FiO2 titrated ↓ to 40% throughout the day. O2 sats remained above 95% - Suctioned prn. - HR 114-140 - Alarms functional

(b)(6)

7p-7a

1918 - Vent ✓ Parameters confirmed. Pt remains int. 7.5 ETT 22 at the lip. Cuff Pressure ✓. BS Essentially clear. HR 145 RR 14 SpO2 97 on 40% Peep 5. Plan to continue to maintain 2° Pt acuity.

(b)(6)

0638 - No Δ's or significant events to note overnight. Parameters + Pt condition remain same. ABG drawn, results pending. HR 139 BP 80/49 RR 40 SpO2 100.

(b)(6)

Task Force 344 Ventilator Flow Sheet

Patient Info: Name: 166576
Age: _____ DOB: _____
Gender: M Pt. ID: _____

Date: 26 JUL 05
Vent Day #: 3
Vent Unit #: 50177

	Time	0700	0730	1130	1400	1710	1907	1100	0300	0600						
	Mode	AC		AC	AC	AC	AC	AC	AC	AC						
Rate	Set	14		14	14	14	14	14	14	14						
	Spont	/		/	/	/	—	—	—	—						
	Total						~~35~~	-	-	-						
Vt	Set	700		700	700	700	700	700	700	700						
	Spont	/					—	—	—	—						
	MV	10.2		10.1	10.2	10.2	10.2	10	10	10.2						
	FiO2	40	35	35	35	35	35	35	~~35~~ 37	35						
	Peep	5		5	5	5	5	5	5	5						
	I/E	1:2		1:2	1:2	1:2	1:2	1:2	1:2	1:2						
	Flow	60		60	60	60	60	60	60	60						
	Sens	-2		-2	-2	-2	2	2	2	2						
	PIP	37		34	37	30	26	34	29	33						
	MAP	12		9	12	9	12	9	8	10						
	Sats	100		96%	96%	100%	100	100	100	100						
	PIP Alarm Hi/LO	50/10		50/10	50/10	50/10	60/10	60/10	50/10	50/10						

(b)(6)

ETT/Trach

Size	Position	Cuff
7.5	22	MLT
7.5	22	MLT

1710 - 1600 PSI
1904 - ~~1800~~ 1500 PSI
0300 - 1000 PSI
0640 - 600 PSI

ABG

Time	PH	PCO2	PO2	TCO2	BE
0600	7.44	33	117	16	-9

HCO3 15.3

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

Task Force 344 Ventilator Flow Sheet
Respiratory Notes

7a-7p

Pt. remained on 754 Vent. AC14/700/35% -Peep 5cm H2O
BBS equal bilaterally suct'd for ..., O2 titrated to 35%.
HR-130's - O2 sat 94-100%. -Alarms on + functional
H Cylinder replaced c a full cylinder @ 1100 Hrs - (b)(6)

7p-7a 1919- Pt remains in critical condition. still Intubated
+ on Vent. Parameters confirmed A/C/14/700/35%/5, BS
essentially clear. HR 123 RR 28 SpO2 100. Pt remains on Pressors.
current Plan is to continue current Level of support
2° Pt acuity. (b)(6)
0630 - ABG + Drawn. No sign. Δ in events [illegible] [illegible] PM. (b)(6)
will Await results before any Δ's.

Exhibit 2

Task Force 344 Ventilator Flow Sheet

Patient Info: Name: 166576
Age: M DOB:
Gender: M Pt. ID :

Date: 27JUL05
Vent Day #: 4
Vent Unit #: 5172

	Time	0830	1111	1345	1415	1587												
	Mode	AC	AC	AC														
Rate	Set	14	14	14	(16)													
	Spont	1	1															
	Total																	
Vt	Set	700	700	700														
	Spont																	
	MV	10.0	10.0	10.3	(100)													
	FiO2	35%	35%	35														
	Peep	5	5	5														
	I/E	1:2	1:2	1:2														
	Flow	60	60	60														
	Sens	-2	-2	-2														
	PIP	31	30	28														
	MAP	10	10	8														
	Sats	97%	97%	100														
	PIP Alarm Hi/LO	50/10	50/10	50/10														

Initials (b)(6)

ETT/Trach

Size	Position	Cuff
7.5	22	MLT

Extubated press. 0830 → 2100 PSI

ABG

Time	PH	PCO2	PO2	TCO2	BE
0600	7.35	23	97	13	-13

HCO3 12

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

Task Force 344 Ventilator Flow Sheet
Respiratory Notes

7a-7p

Pt. remained on 754 vent - AC14/700/35%/Peep5 - BSS equal
HR 120's - RR 40's -
@ 1445 hrs pt.'s HR gradually down, cardiac meds given + FiO2 ↑ed to
100% - abg drawn - 7.16/37/302/HCO3 11.8/99% - AC rate ↑ed to 16 bpm
as per physician -
1512 hrs - CPR started - pt. manually ventilated c 100% O2 - till code
called off - @ 1529 hrs

(b)(6)

7p-7a

Task Force 344 Ventilator Flow Sheet

Patient Info: Name: 166576 Date: 1310 HRS / 24 HRS

Age: ____ DOB: ____ Vent Day #: 1

Gender: M Pt. ID: ____ Vent Unit #: ____

	Time	1315	1530	1700	1848	1947	0203									
	Mode	AC	AC	AC	AC	A/C	A/C									
Rate	Set	14	14	14	14	14	14									
	Spont	—				—	—									
	Total	14	14		14	14	14									
Vt	Set	600	600	700	700	700	700									
	Spont					—	—									
	MV					—	—									
	FiO2	100	100		100	100	100									
	Peep	—	—	5	5	5	5									
	I/E	1:2.9	1:2.9		1:2.9	1:2.9	1:2.9									
	Flow	—	—		—	—	—									
	Sens	DR	—		—	2	2									
	PIP	29	31		34	33	25									
	MAP	9	9		15	15	11									
	Sats				94	98	89									
	PIP Alarm Hi/LO	50/10	50/10	50/10	50/10	50/10	50/10									

Initials (b)(6)

ETT/Trach

Size	Position	Cuff
7.5	~~24~~ 22	MLT
7.5	22	MLT

ABG

Time	PH	PCO2	PO2	~~TCO2~~ HCO3	BE
1410	7.18	45	101	18	-12
1630	7.25	30	62	14.4	-12
1800	7.34	28	72	15.0	-11

Cylinder pressure

TIME: 1530 / 1600 PSI

1700 / 1300 PSI

1800 / 1600 PSI

2230 / Δ Tank 1000 PSI

0204 / 500 PSI

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

Task Force 344 Ventilator Flow Sheet
Respiratory Notes

7a-7p

1315 Hrs Pt orally intubated c 7.5 ETT. done as ordered by (b)(6). BSS equal bilaterally - Placed on 754 Impact Vent: Ac 14/600/100%. Suctioned DAN - ABG pending (b)(6)

1820 Hr Pt remains on vent - Ac 14/700/100/Peep 5 cmH2O - Several abg's drawn + reported. BSS equal/clear to all fields except ↓d to (L) middle lobe (anterior) - ETT pulled back to 22 cm mark by CPT Estes - X-ray was done + verified. (b)(6)

7p-7a

1950 - Vent ✓ Done Parameters confirmed. Pt sedated. BS course crackles at the Bases. Clear upper lobes HR 115 RR 14 SpO2 97 on 100% Peep 5. Plan to maintain (b)(6)

0203 - Vent ✓ Done Parameters maintained. No Δ in BS. HR 119 RR 14 SpO2 98 on 100% Peep 5 (b)(6)

0517 - Vent Δ 2° Low External Power + Low Battery alarms will send vent to Bio-Med for maintenance. Parameters maintained in new vent. Pt Bagged on 100% while Δ being done. No adverse reactions (b)(6)

Medical

Detainee Movement Sheet

Compound # 1 Date: 4 JULY 05

	ISN #	Comp Moved From	Losing CCT Initials	Comp Moved To	Gaining CCT Initials	Reason For Move	Approving Authority
1	166576	1	(b)(6)	MED	(b)(6)	ADMISSION	SCHUH
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							

THIS IS FOR PERMANENT MOVES ONLY. If a detainee is going to medical for a check up or an appointment then you ONLY annotate the information in the compound journal. DO NOT PLACE A DETAINEE ON A MOVEMENT SHEET UNLESS THE MOVE HAS BEEN APPROVED AND THE MOVEMENT IS PERMANENT. Prior to any movement in the Internment Facility authorization must be given by the Facility CDR; Facility SGM; Chief DOB; or the Chief DSB. A move into segregation is authorized by the OIC or SOG for major rules violations and /or disciplinary reasons without approval from the above, however notification must be made.

Approving Authority: CRAIG SCHUH, MAJOR OPERATIONS OFFICER.

Approving Authority Signature: (b)(6) S3

0073-05-CID579-40022

MILITARY OPERATIONS
RECORD OF PERSONAL EFFECTS OF DECEASED PERSONNEL

1. DATE (YYYYMMDD)	2. PAGE
2005 Jul 27	OF

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC Sections 1481 through 1488, EO 9397, Nov. 1943 (SSN).

PURPOSE AND USE: This form is used to establish initial identification of deceased personnel.

DISCLOSURE: Personal information provided on this form is given on a voluntary basis. Failure to provide this information, however, may result in improper identification of the deceased person and person making visual identification.

3. TENTATIVELY IDENTIFIED DECEDENT

a. NAME (Last, First, Middle Initial) (or Unidentified)	b. GRADE	c. SSN	d. ORGANIZATION	e. STATUS	f. DATE OF STATUS (YYYYMMDD)
Atowi, Ahmed Ismail Detainee #6576					

4. PLACE OF RECOVERY (Include grid coordinates)	5. DATE OF RECOVERY (YYYYMMDD)	6. EVACUATION NUMBERS a. #1	b. #2

7. INVENTORY OF EFFECTS

a. QUANTITY	b. DESCRIPTION	c. RECEIVED	d. CONDITION	e. DISPOSITION

8. FUNDS/NEGOTIABLE INSTRUMENTS/OTHER HIGH VALUE ITEMS TRANSMITTED WITH EFFECTS

a. QUANTITY	b. DESCRIPTION	c. RECEIVED	d. CONDITION	e. DISPOSITION

9. EFFECTS INVENTORIED ABOVE REPRESENT (X as appropriate)

☐ ALL KNOWN EFFECTS ☐ ALL KNOWN EFFECTS RECOVERED FROM UNIT ☐ ALL KNOWN EFFECTS RECOVERED FROM REMAINS

10. PREPARING OFFICIAL

a. NAME (Last, First, Middle Initial)	b. GRADE	c. ORGANIZATION	
d. SIGNATURE			e. DATE SIGNED (YYYYMMDD)

11. RECEIVING OFFICIAL

a. NAME (Last, First, Middle Initial)	b. GRADE	c. ORGANIZATION	
d. SIGNATURE			e. DATE SIGNED (YYYYMMDD)

12. RECEIVING OFFICIAL

a. NAME (Last, First, Middle Initial)	b. GRADE	c. ORGANIZATION	
d. SIGNATURE			e. DATE SIGNED (YYYYMMDD)

STATEMENT OF IDENTIFICATION

For use of this form, see AR 638-2; the proponent agency is ODCSPER

NAME OF DECEASED (Last, First, MI)	GRADE	SSN	BRANCH OF SERVICE	DATE OF INCIDENT
Atawi, Ahmed Ismail	Detainee	#166576		

ORGANIZATION AND BASE: 344th Combat Support Hospital

PLACE OF DEATH/INCIDENT: Same

CONDITION OF REMAINS *(Describe briefly in Narrative below)*

(Recognizable)	Not Recognizable	Commingled	Mutilated
Burned	Decomposed	Semi-Skeletal	Skeletal

MEANS OF IDENTIFICATION *(Check all appropriate boxes. Specify supporting data in Narrative below)*

Fingerprint Comparison	Footprint Comparison	Dental Comparison	Anatomical Comparison
Skeletal Comparison	Personal Effects	Visual Recognition	Identification Tag(s)
Other *(Explain in Narrative)*			

ENCLOSURES

DD Form 565	DD Form 890	DD Form 891	DD Form 892
DD Form 893	DD Form 894	DD Form 897	ID Card
DD Form 369	FD 258	AF Form 137	SF 603
Dental X-Rays	SF 88	SF 93	DD Form 2064
SF 601	Photo		

NARRATIVE AND SUMMARY *(Continue on reverse or use additional sheets, if required)*

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	AUTHORIZATION FOR AUTOPSY

In the event authorization for autopsy is obtained by letter, telegram, voice recorded or monitored telephone call, paragraphs 1, 2, and 3 all be completed by medical facility authorities and the letter, telegram, voice recording or memorandum confirming telephone call of thorization attached to this form for permanent file. (Detainee death)

1. NAME AND LOCATION OF MEDICAL FACILITY	DATE AND TIME
344th Combat Support Hospital, Camp Bucca Iraq	

2. I(We) request and authorize the physicians in attendance at the above named medical facility to perform a complete autopsy on the nains of _____

/e) understand that a complete autopsy may include, but not be limited to, examination of the head, eyes, spinal cord, chest, abdomen and remities unless excluded under restrictions hereinunder, and I(We) authorize the removal and retention or use for diagnostic, scientific, or rapeutic purposes any parts, tissues, or organs as such physicians or their designees may deem proper, and the final disposal thereof in such inner as may be prescribed by competent authority (Commanding Officer, Medical Director, etc.) in this facility.

This authority is granted subject to the following restrictions: _____

(If No Restrictions, Write "None")

The following special examinations are requested: _____

3. I(We) represent that I am (we are) the _____ (Realtionship/Authority)

the deceased and entitled by law to control the disposition of the remains.

Signed _____

TNESSES (medical facility staff members):

Signed _____

gned _____ (Name and Title)

gned _____ (Name and Title)

FOR ADMINISTRATIVE USE ONLY

Case falls within jurisdiction of Medical Examiner/Coroner . . . . . ☐ YES ☐ NO

Medical Examiner/Coroner released remains from his jurisdiction to this authority . . . . . ☐ YES ☐ NO

SNATURE	TITLE	DATE

TIENT'S IDENTIFICATION *(For typed or written entries give: Name–last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

AUTHORIZATION FOR AUTOPSY
Medical Record

ACLU DDII CID ROIS 38936

ACLU-RDI 5494 p.55

000059

STANDARD FORM 523 (REV. 12-83)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1
*U.S. GPO: 2000-461-707/20304

Exhibit 2

DOCTOR'S ORDERS - *(SIGN ALL ORDERS)*

For Each Set of Orders. Record the Date and Time. Sign. and Cross Out the Unused Lines

PATIENT IDENTIFICATION

166576
Atawi, Ahmed Ismail
ICU 1

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 25 Jul 05 TIME 1145 | NURSE'S SIGNATURE

Rocephin 2gm IV X 1
Tylenol 500mg per NGT or per rectum TID for fever

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)
7/26/05
193lbs

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 25 Jul 05 TIME 1450

Give extra 40mg lasix @ 1600 ~~Hold~~

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 25 Jul 05 TIME 0930

1) May switch norepi to epinephrine when out of stock. Mix 2mg epi in 250cc D5W (8mcg/cc) Infuse at 2mcg/min and titrate to keep SBP >80
2) Hold lasix

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER TIME

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM 0800 HOURS TO 0800 HOURS	TOTAL HOURS COVERED 24	DATE 24Jul05

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0900	500↑	Albumin in NS	500	1420	5200
1030	↑1000	LR 5% Dextrose	774	1630	774
1325	400↑	Dopamine in D5W			
1420	50ml↑	Diprivan			
1300	2mg	Vecuronium			
1305	2mg	Vecuronium			
1630	995↑	LR D5% 2Amp Sodi. bicarb.			
1745	50↑	Zantac			

IRRIGATIONS (*N.G. Bladder, etc.*)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (*i.e. Bl. Alb. P. cells. etc.*)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
4 July 05 7:00	S- Hypo-volemic Hypo tension Hepato Failure No oral intake O- Lung CM Hyper- V.S. 92/58 117 3 79/41 163 38 81/48 112 57 Lab. alb <1.0 wbc 14,600 alp 162 Hb 9.3 alt 122 Hct 30 AST 387 mcv Tbil 0.5 mch BUN 25 MCHC 31 Creatinine 1.3 glucose 169 125 5.7

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)		REGISTER NO.	WARD

#166576

Atawi, Ahmed Ismail

ICU Bed 1

CHRONOLOGICAL RECORD OF MEDICAL
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR 141 CFR 201-45.505

Exhibit 2

0073-05-CID579-40022

PATIENT IDENTIFICATION

166576
Bed 17

DATE OF ORDER 22 Jul 05 TIME 1530 NURSE'S SIGNATURE

Provide detainee with baby powder (1% Hydrocortisone) to apply to groin daily (b)(6)

22 July 05 (b)(6) 1533 hrs

NURSING UNIT ICU ROOM NO. BED NO. 17 24 chart / 23 Jul 05 (b)(6)

PATIENT IDENTIFICATION (b)(6)

Noted 22 July 05 2030

DATE OF ORDER 20050722 TIME 2020

Percocet 2 PO now, please then 1-2 q 4-6 PRN (b)(6)

NURSING UNIT ICU ROOM NO. BED NO. 5 24 chart / 23 Jul 05 (b)(6)

PATIENT IDENTIFICATION

Noted 22 July 05 2331

DATE OF ORDER 22 July 05 TIME 2300

D/C Percocet

Toradol 30 mg IVP q6 prn pain

~~Reglan 10 mg IVP q6 prn~~ (b)(6)

NURSING UNIT ICU ROOM NO. BED NO. 12 24 chart / 23 Jul 05 (b)(6) 0300

PATIENT IDENTIFICATION

166576

DATE OF ORDER 23 Jul 05 TIME 1000

1) IV access, Central IV access
2) Bolus 500cc NS, Obtain ABG, - done
3) Obtain CBC & diff, Chemistries, LFTs done
4) Place foley Catheter.
5) O2 4L NC
6) Transfer to ICU
7) 1 gm dextrose IVP
8) Continue NS @ 250cc/hr x 1 Lite
9) AM Chem 8, CBC

(b)(6)

NURSING UNIT ICU ROOM NO BED NO 12

AF FORM 3066-1, 19870401 (EF-V2) RECORD

ACLU DDII CID ROIS 38940
000063

ACLU-RDI 5494 p.59

Exhibit 2

For use of this form, see AR 190-8; the proponent agency is DCSPER. 166576

FROM: **FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE** 0073-05-CID579-40022

TO:

NAME *(Last, first, MI)*	GRADE	SERVICE NUMBER
Afawi, Ahmed Ismail (Detainee)		

NATIONALITY	POWER SERVED	PLACE OF CAPTURE/INTERNMENT AND DATE

PLACE OF BIRTH	DATE OF BIRTH

NAME, ADDRESS, AND RELATIONSHIP OF NEXT OF KIN	FIRST NAME OF FATHER

PLACE OF DEATH	DATE OF DEATH	CAUSE OF DEATH
44th CSH. Camp Bucca, IRAQ		

PLACE OF BURIAL	DATE OF BURIAL

IDENTIFICATION OF GRAVE

PERSONAL EFFECTS *(To be filled in by Office of Deputy Chief of Staff for Personnel)*

___ RETAINED BY DETAINING POWER ___ FORWARDED WITH DEATH CERTIFICATE TO *(Specify)* ___ FORWARDED SEPARATELY TO *(Specify)*

BRIEF DETAILS OF DEATH/BURIAL BY PERSON WHO CARED FOR THE DECEASED DURING ILLNESS OR DURING LAST MOMENTS
(Doctor, Nurse, Minister of Religion, Fellow Internee). IF CREMATED, GIVE REASON. *(If more space is required, continue on reverse side).*

Admitted 4 Jul 2005 with hepatic failure. Workup revealed advanced Stage malaria. Course complicated sepsis and multiorgan failure requiring mechanical life support. No response to antibiotics. Expired from irreversible shock and acidosis

(b)(6)

DO NOT WRITE IN THIS SPACE
CERTIFIED A TRUE COPY

DATE

SIGNATURE OF COMMANDING OFFICER

WITNESSES

SIGNATURE ADDRESS

SIGNATURE ADDRESS

DA FORM 2669-R, MAY 82 EDITION OF 1 JUL 63 IS OBSOLETE. USAPPC V1.00

Exhibit 2

FOR USE OF THIS FORM, SEE AR 40-2; THE PROPONENT AGENCY IS THE OFFICE OF THE SURGEON GENERAL

FOR OFFICIAL USE ONLY/LAW ENFORCEMENT SENSITIVE

0073-05-CID579-40022

Instructions - Medical Officer in attendance will:

Prepare, in one copy only, Items 1 through 10 and sign Item 11. Send form, without delay, to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

Print or type entries.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*	2. TIME OF DEATH *(Hour-day-month-year)*	3. MEDICAL EXAMINER/ CORONER'S CASE
Afawi, Ahmed Ismail Detainee #166576	1529, 27 July 2005	☒ YES ☐ NO
Patient's name (Last, first, middle initial), Grade, Social Security Account No., Register Number and Ward Number	4. RELIGION	5. CHAPLAIN NOTIFIED ☐ YES ☐ NO
	6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH	

CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* Septic Shock	4 days
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1) Hepatic failure	> 1 month
	(2) Malaria	> 1 month
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a. Malnutrition	> 1 month
	b.	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE
27 Jul 2005	(b)(6)	(b)(6)

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☐ NO	21. AUTOPSY ORDERED BY *(Signature)*
22. PROVISIONAL PATHOLOGICAL FINDINGS	

23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY	25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
26. DATE	27. TYPED NAME AND GRADE OF REGISTRAR	28. SIGNATURE OF REGISTRAR

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP								
Pulse								
Respirations								
Temperature								
SaO2								
%O2								
O_2 Delivery								
CVP								
Pain Scale								
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT		
OUTPUT		
DIFFERENCE		

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
IV										
IVBP										
PO										
Other										
TOTAL										

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total										
NG output										
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										

Legend

Init=initials
JVD=Jugular Venous Distention
L=Left
NIBP=Noninvasive Blood Pressure
N=No
Y=Yes
P=Prone
R= Right
SaO2=Saturation of Arterial Oxygen
S= Supine
ABP= Arterial Blood Pressure
PS=Pharmacologically Sedated

Name	Signature	Init
(b)(6)		

AC

SYSTEM	DAYS	NIGHTS
NEURO		
Level of consciousness	No respond to tactile stimuli	
Extremities: Movement		
Strength	now, flaccid	
PAIN ASSESSMENT		
pupils	Sluggish, 4mm, bilateral eyes taped to prevent abrasion	
CARDIOVASCULAR		
Rhthym/Lead	Sinus tach @ 138	
Heart Sounds	S1 S2	
Skin	pitting edema generalized.	
Edema	weeping edema (R) groin	
JVD/ Capillary refill	< 3 sec	
Pulses: Radial	— trace	
Posterior Tibial	unable to palpate due to edema	
Dorsalis Pedis		
RESPIRATORY		
Breath Sounds	diminish all lung field.	
Oxygen Delivery	vent 35% TV 700 14 peep 5	
Suctioning/Sputum	thick whitish mucous, sml amt	
ETT/Trach tube	7.5cm (R) side	
Size Placement	22cm	
Cough	—	
Treatments	suctioning PRN	
GASTROINTESTINAL		
Bowel Sounds	hypoactive	
Abdomen	firmly distended.	
Date of last BM	?	
NG tube: Placement	(R) nare	
Suction	intermittent	
Drainage	greenish	
GENITORURINARY		
Urine: Color	concentrated yellow	
Void/Foley	Foley visitu 16F	
INTEGUMENTARY		
Integrity	poor. Stage I decubitus (R) ear lobe	
Dressings	Stage I decubitus sacral	
	Pt unable to tolerate turning	
Dressing Condition	activity. Hemodynamic unstable.	
	↓ BP. Bilateral upper & lower	
Drains/Tubes	extremities elevated on pillows	
Drainage	oozing clear fluid (R) groin, dressing applied	
Signature	(b)(6)	

ime	07	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22	
IBP/ BP	86/45	85/49	87/51	84/140	84/	86/58	77/33	77/35										
ulse	139	138	140	140	141	135	131	131										
espirations	45	44	43	39	45	37	35	39										
emperature		101				101.9												
aO2	100	100	100	100	100	100	100	100										
O2	35%	35%	35	35	35	35	35	35										
O_2 Delivery	vent	vent	vent	vent	vent	vent	vent	vent										
VP	10	9	11	11	16	12	10	9										
ain Scale	-	-																
ain Med																		
t Position	SF 30	SF 30	SF	SF	SF	SF	SF	SF										

Please refer to code sheet

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
V Atiran	Dc	stopped		& D/C					10									
VPB	(45mg)			2antec 50		except 100		Flagyl 08										
Levophed	42	42	42	42↑	40	30	20	20	278									
DSLR	50	50	50	50	150	50	50	50	400									
O																		
Other																		
TOTAL									688									

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output Hour/Total	0	0	0	0	0	0	0	0	0									
NG output																		
Emesis																		
Stool																		
Chest tube #1/ #2																		
Jackson Pratt #1/ #2																		
TOTAL									0									

ASPECT	TIME/INITIALS
Bath/Skin Care	0800 (b)(6)
Oral Care	0800
Foley Care	0800
Trach Care	NA
Range of Motion	0800

Safety	D	E	N
High risk for falls	(Y) N	Y N	Y N
Call bell in reach	Y (N)	Y N	Y N
Bed position/Locked	(Y) N	Y N	Y N
Protective device	Y (N)	Y N	Y N
Cardiac Monitor	(Y) N	Y N	Y N

Exhibit 2

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

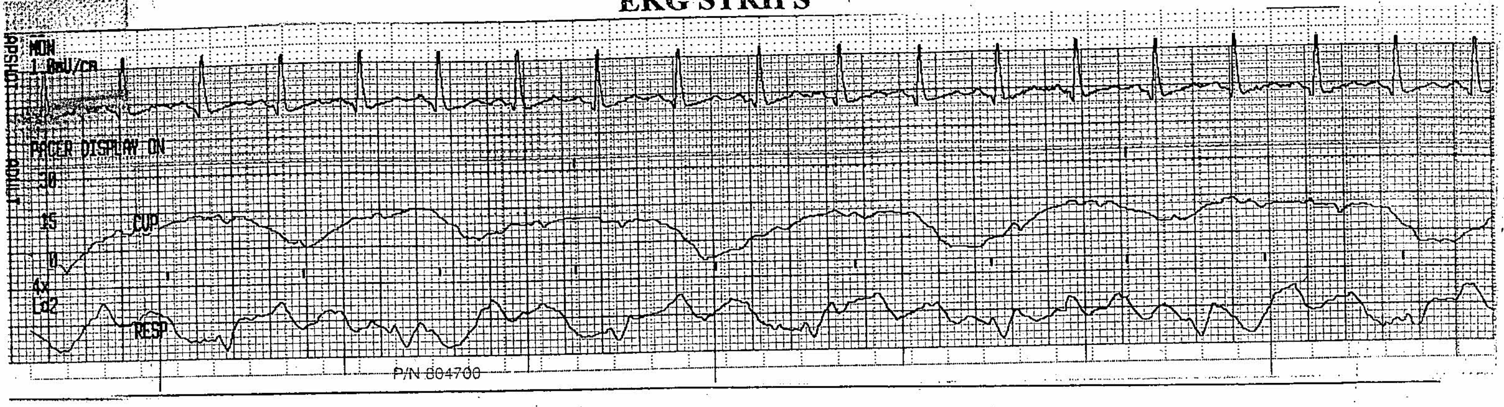
FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

REPORT TITLE

ICU FLOW SHEET

OTSG APPROVED (Date) 0073-05-CID579-40022

EKG STRIPS



VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
Fr CVP (R) subclavian	25 Jul 05	29 Jul 05	clean, dry & intact		

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
(b)(6)	ICU Bed 1	27 Jul 05

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

Atawi, Ahmed Ismail

166576

- [ ] HISTORY/PHYSICAL
- [ ] OTHER EXAMINATION OR EVALUATION
- [ ] DIAGNOSTIC STUDIES
- [ ] TREATMENT
- [x] FLOW CHART
- [ ] OTHER (Specify)

DA FORM 4700, MAY 78

USAPPC V2.00

Exhibit 2

ACL [redacted]

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

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0073-05-CID (b)(6)

1200. Pt status unchanged, continue to [redacted] IV Levophed.

1405. Patient HR ↓ 50, unable to obtain BP, full code called.

(b)(6) notified. Please refer to code sheet.

~~1430~~ 1530 PAD & TOC notified. CID notified by PAD & TOC. Awaiting retinal scan from CID.

1604. S/B CID.

1630. Body to processing center for retinal scan (b)(6)

STANDARD FORM 600 (REV. 6-97) GAC

Exhibit D

AUTHORIZED FOR LOCAL REPRODUCTION

0073-05-CID579-40022

5640-00-634-4178

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDICAL RECORD

TREATING ORGANIZATION (Sign each entry)

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT
6 JUL 05 2000 hrs	Received clnt: Stm fowler on right side. Blood pressure stable, but fluctuates. Lungs diminished to all fields, patient to left base ETT in place. Temp = 35 Generalized pitty edema. Urine oliguric.
2100 hrs	(b)(6) Concentration of Levophed changed to dilute fluid intake Stable. Blood pressure stable, but remains low, Levophed increased to 40mcg/min in attempt to reach target B/P Slight increase in B/P noted.
2300 hrs	Levophed increased due to blood pressure readings. Placed supine and in low fowlers to increase B/P.
0200 hrs	B/P remain low, but stable. Patient no longer being turned due to instability while turned on side.
0600 hrs	State unchanged. Blood sugar remain at acceptable levels
0700 - 0800	AM care done with 2 assist. Assessment done, vital signs taken IV Levophed 16mg/NS 250cc @ 45 mcg/min, IV DSLR @ 50cc/hr, IV Ativan stopped to reevaluate pt ~~sedation~~ mental status:
1000.	S/B (b)(6) . Orders received & implemented by RN. IV Ativan pt'd by RN. Pt remains unresponsive. IV Levophed on titration. Continue to monitor.

(b)(6)

HOSPITAL OR MEDICAL FACILITY | STATUS | /SERVICE | RECORDS MAINTAINED

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR | REGISTER NO. | WARD

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

#166576

CHRONOLOGICAL RECORD OF MEDICAL

Medical Record

STANDARD FORM 600 (REV. 6-97)

Prescribed by GSA/ICMR

FIRMR 141 CFR 201-9.202-1

Exhibit 2

ACLU DOJ CID POIS 28949

ACL

POST OPERATIVE DAY | PHYSICIAN

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

0073-05-CID579-40022

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP	73/47	70/44	88/54	77/49	75/47	77/51	79/51	80/47
Pulse	131	132	133	136	137	138	138	138
Respirations	40	38	34	40	38	35	40	38
Temperature								
SaO2	100	100	100	100%	100%	99%	100%	100%
%O2	Vent	35%	35%	36%	36%	36%	35%	35%
O_2 Delivery	35%	Vent	Vent	Vent	Vent	Vent	Vent	Vent
CVP	12	12	12	11	14	12	11	
ePO	↑45mg	45mg	45mg	45mg	45mg	45mg	45mg	45mg
Pain Scale	—	—	—	—	—	—	—	—
Pain Med	—	—	—	—	—	—	—	—
Pt Position	L/S	S	S	S	S	S	S	S

24 Hour Totals	Yesterday	Today
INPUT		
OUTPUT		
DIFFERENCE		

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
IV D_5LR	50	50	50	50	50	50	50	50	400	1200
IVBP	Flagyl 100	Zantac 50						Flagyl 100	250	
Ativan	10	10	10	10	10	10	10	10	80	
Levophed	42	42	42	42	42	42	42	42	336	
PO	~	PO								
Other										
TOTAL										

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total	10/10	0/10	10/20	0/20	15/35	10/45	10/55	10/65	65	335
NG output									200	550
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										

Legend

nit=initials
VD=Jugular Venous Distention
.=Left
IBP=Noninvasive Blood Pressure
I=No
'= Yes
P=Prone
R= Right
SaO2=Saturation of Arterial Oxygen
S= Supine
ABP= Arterial Blood Pressure
PS=Pharmacologically Sedated

Name	Signature	Init
(b)(6)		
(b)(6)		

Exhibit 2

AC [redacted]

SYSTEM	DAYS	NIGHTS
NEURO	26 Mar 03 0800 hrs	26 Mar 03 2000 hrs
Level of consciousness	sedated	sedated
Extremities: Movement	unable to assess, sedated.	sedated
Strength		sedated
PAIN ASSESSMENT		sedated
Pupils	4mm, sluggish	4mm, sluggish, eyes taped closed
CARDIOVASCULAR		
Rhthym/Lead	sinus tachy @ 136	sinus tachycardia c ectopy
Heart Sounds	S. S.	S, S, rated
Skin	pitting edema generalized +4	pitting edema LE > UE.
Edema		skin intact
JVD/ Capillary refill	< 3 secs	no JVD; Cap. refill < 3 sec.
Pulses: Radial	unable to palpate	+/+
Posterior Tibial		unable
Dorsalis Pedis		+/+
RESPIRATORY		
Breath Sounds	diminished all lungs field	accessory muscle use noted generally diminished anteraly
Oxygen Delivery	ventilator FIO2 35%, Tv 700 14	Vent. 14 700 35% peep 5
Suctioning/Sputum	peep 5	
ETT/Trach tube	7.5cm (R) side	7.5 ETT 22@ lip
Size Placement	22cm site change by (b)(6)	
Cough	suctioning thick whitish mucus	suctioned
Treatments		
GASTROINTESTINAL		
Bowel Sounds	Hypoactive	hypoactive
Abdomen	distended, firm	distended firm
Date of last BM	?	
NG tube: Placement	(R) nare	LIS
Suction	intermittent low cont	bilious
Drainage	greenish	bilious
GENITORURINARY		
Urine: Color	concentrated yellow.	Concentrated amber
Void/Foley		#16 Fr
INTEGUMENTARY		
Integrity	generalized pitting edema 4+	Stage I to sacrum
Dressings	weeping edema (R) groin	(R) groin old TLC
	stage 1 decubitus sacral	
Dressing Condition	Turn & reposition Q2H.	old sacrum
Drains/Tubes		N/A
Drainage		
Signature	(b)(6)	(b)(6)

Exhibit 2

Time	07	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22	
NIBP/ ABP	82/44	84/45	91/49	84/50	9[illegible]	83/51	4?/45	?/39		?/44	?/36	82/38	[illegible]/51	?/46	79/48	84/49	88/48	
Pulse	137	136	133	135	134	135	136	138		136	144	137	131	128	130	132	136	
Respirations	40	42	41	37	48	41	25	46		47	34	30	28	41	40	36	38	
Temperature	100.3					101.2	Tylenol	99.2							100.6 (A)			
SaO2	99	99	100	100	100	100	93	95		95	100	100	100	100	100	100	100	
%O2	35%	35%	35%	35%	35%	35%	35%	35%		35%	35%	35%	35%	35%				
O2 Delivery	TV 700 Peep 5 Vent 14	vent	vent	vent	vent	vent	vent	vent		vent	vent	vent	vent	vent	Vent	Vent	Vent	
CVP	20	13	15	14	14	10	8	7		4	13	13	14	15	18	18	16	
LEVO														37.5 mcg	↑40 mcg	40 mcg	40 mcg	
Pain Scale	0	0	–	–	–	–	–	–		–	–	–	–	–	–	–	–	
Pain Med	0	0	–	–	–	–	–	–		–	–	–	–	–	–	–	–	
Pt Position	(R)	R	L	L	R	R	~~B~~ S	L		L	S	S	R	R	S	S	L	

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV D5LR	50	50	50	50	50	50	50	50	400	50	50↑	50	50	50	50	50	50	400
IVPB						Erythro 100	Zantac 100	Flagyl 100	300									
IV Ativan	21	21	21	21↑	21	21	21	21	168	↑21	21	21	15	10	10	10	10	118
IV Levophed	47	47	47	47↑	47	47	47	47	516	47	47	70 ~~50~~	70	70	70	38	38	450
					40mg Lasix						Lasix 40mg					Concentration of Levo Δ ×9		
PO	—	—	N	P	O —	—	—	—										
Other																		
TOTAL									1,364									

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output Hour/Total	10	20	20	20	20	20	20	20	150	0	0	20	10	10	25	30	25	(120)
NG output														150				(200)
Emesis																		
Stool																		
Chest tube #1/ #2																		
Jackson Pratt #1/ #2																		
TOTAL																		

ASPECT	TIME/INITIALS	
Bath/Skin Care	0800	(b)(6)
Oral Care	0800	
Foley Care	0800	
Trach Care	— NA —	—
Range of Motion	0800	(b)(6)

Safety	D	E	N
High risk for falls	(Y) N	Y N	Y N
Call bell in reach	(Y) N	Y N	Y N
Bed position/Locked	(Y) N	Y N	Y N
Protective device	Y (N)	Y N	Y N
Cardiac Monitor	(Y) N	Y N	Y N

Exhibit 2

[redacted]

MEDICAL RECORD SUPPLEMENTAL MEDICAL DATA

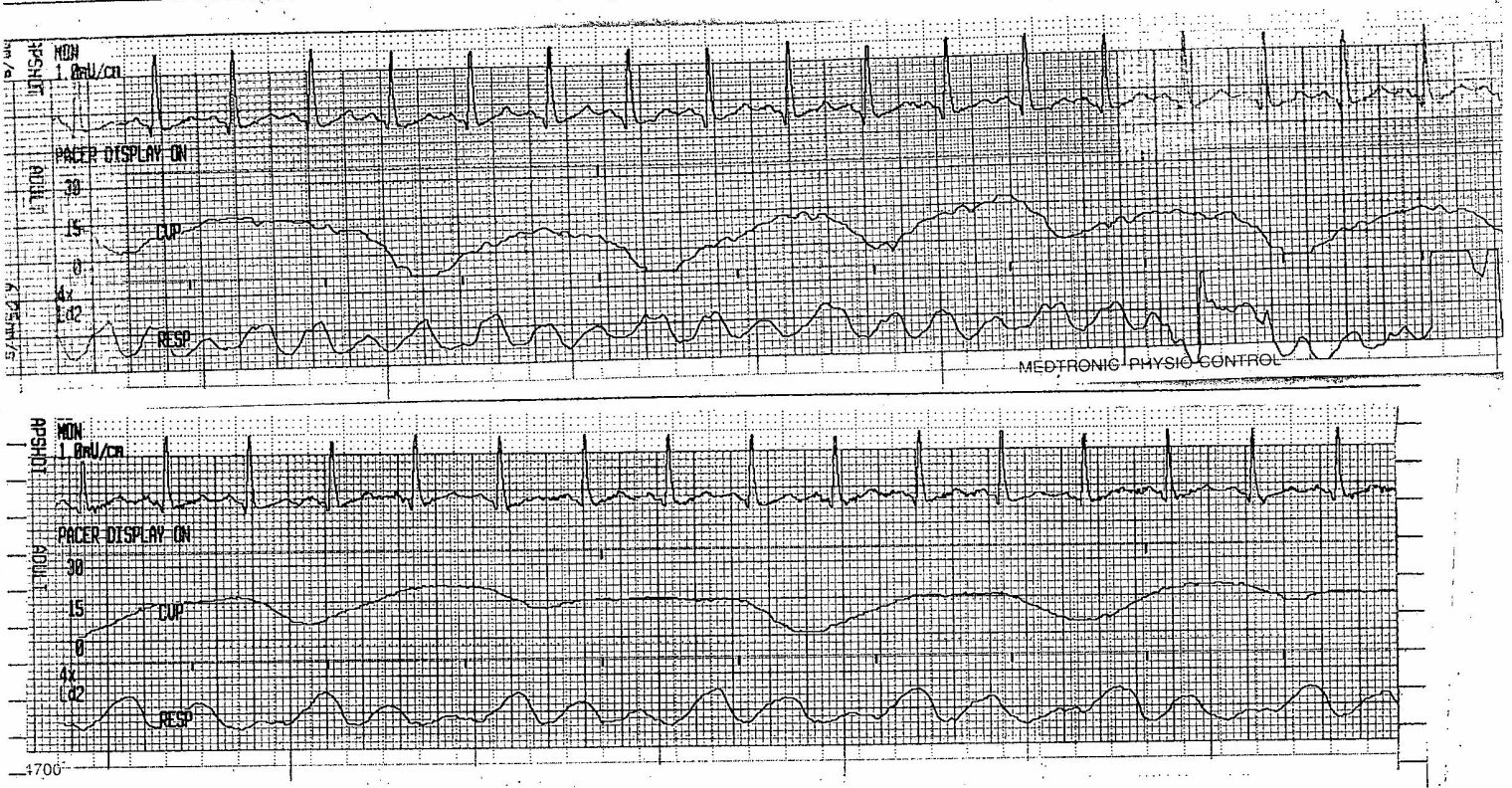
For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General.

ORT TITLE

OTSG APPROVED *(Date)*

ICU FLOW SHEET

EKG STRIPS



VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
F CVP ® subclavian	25 Jul 05	29 Jul 05	clean, dry & intact	dressing changed by RN	

(Continue on reverse)

REPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
(b)(6)	ICU Bed 1	26 Jul 05

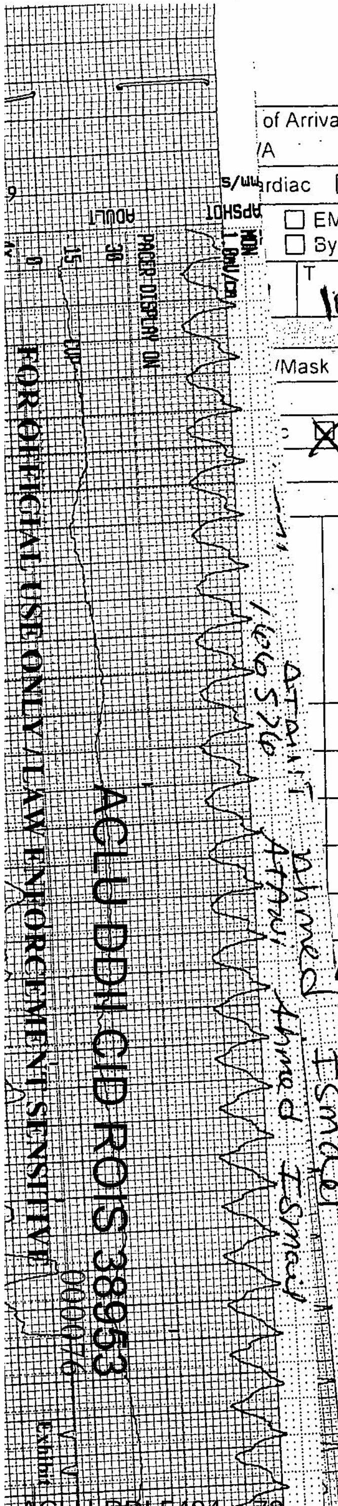
ATIENT'S IDENTIFICATION # or typed or written entries give: Name – last, st, middle; grade; date; hospital or medical facility)

Atari, Ahmed Ismail.
#166576

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00



...of Arrival in ED	Time & Location of Arrest	Hx of Event
...A	1405 ICU	Hx of Malaria, Hypoglycemia, Hyponatremia, Liver Failure (Renal)

...rdiac ☐ Respiratory ☒ Witnessed ☐ Unwitnessed

☐ EMS ☐ Bystander | ALS Started ☐ EMS ☒ Hospital Staff

T 101.9 | P 218 | R 25 | Wt. 150

Procedures Performed

.../Mask Pt on ventilator (Bag/Endo Tube)

Size By See chart No. Attempts

☒ Trach Placement Confirmed By

Size By See chart

Intraosseous: Time	Size & Site	By	No. Attempts
Venipuncture: Time	Size & Site	By	No. Attempts
Venipuncture: Time	Size & Site	By	No. Attempts
Central Venous Catheter: Time	Size & Site	By	
Foley Cath: Time	Size	By	

SpO2	Defib. Joules	EPI 1:1,000	EPI 1:10,000	Atropine	Lidocaine	Sodium Bicarb 8.4%	Calcium Chloride 1:360 meq/ml		Rhythm Response	Dopamine	Lidocaine	IV Fluid Bolus				ABG Drawn (✓)	Nurse's Notes (pO2, pCO2, pH, Color, Mental Status, Temp., Pupils, Procedures, etc.)
				1Amp													
			1														
100																	
93						1Amp										✓	ABG results noted by (b)(6)
99																	
100																	
mapl						1Amp											
							10ml										

...o Patient expired at 1529 Pronounced by (b)(6)

...ient: Time 1535 Location ICU

Attending called (b)(6) (b)(6)

(b)(6) (b)(6)

(b)(6)

Physician S...

R.N. Signatu... (b)(6)

PATIENT IDENTIFICATION

166596

Atani, Ahmed Ismail

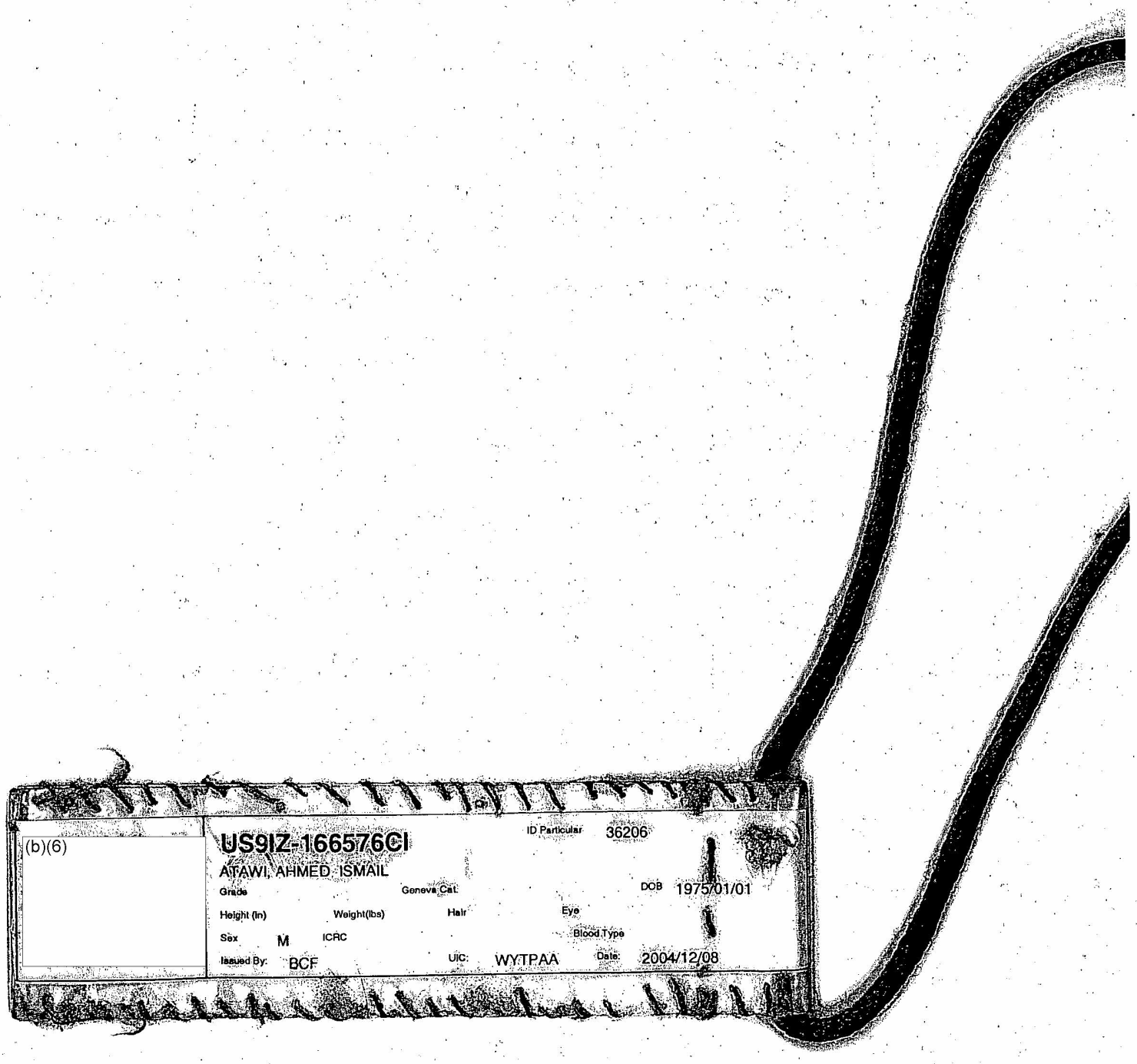

(b)(6)
US9IZ-166576CI
ID Particular 36206
ATAWI, AHMED ISMAIL
Grade
Geneva Cat
DOB 1975/01/01
Height (in)
Weight(lbs)
Hair
Eye
Sex M
ICRC
Blood Type
Issued By: BCF
UIC: WYTPAA
Date: 2004/12/08

Exhibit 2

(b)(6)

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT SENSITIVE

0073-05-CID579-40022

MENTAL HEALTH SCREEN

ISN 166576

Date 9 Dec 04

1. Do you presently have thoughts of killing yourself?	___ Yes	✓ No
2. Have you ever tried to kill yourself?	___ Yes	✓ No
3. Are you presently taking a prescribed medication for a mental Illness or psychological problem?	___ Yes	✓ No
4. Do you have any psychological problems right now?	___ Yes	✓ No
5. Are you currently being treated for a psychological problem?	___ Yes	✓ No
6. Have you ever been a patient in a psychological hospital?	___ Yes	✓ No
7. Do you have a history of treatment for illegal drug abuse?	___ Yes	✓ No
8. Have you been treated for a psychological problem prior to Coming to Abu Ghraib?-	___ Yes	✓ No

OBSERVATION

• General appearance adequate	✓ Yes	___ No
• Behavior adequate	✓ Yes	___ No
• Evidence of abuse	___ Yes	✓ No
• Evidence of trauma	___ Yes	✓ No
• Auditory or Visual Hallucinations	___ Yes	✓ No
• Appears anxious	___ Yes	✓ No
• Appears depressed	___ Yes	✓ No
• Aggressive	___ Yes	✓ No

DISPOSITION

- ✓ If detainee answers no to all of the above questions no psych consult needed.
- ___ If detainee answers yes to questions 2, 4, 6, 7, or 8 fill out consult form for psych and bring to morning meeting.
- ___ If detainee answers yes to questions 1, 3, or 5 contact mental health care services ASAP.

SCREENER (b)(6)

Signature (print/sign)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS; DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
28 Jan 05 Date	S: 30yo ♂ c/o: Strong pn in upper (L) abdomen since
108 P	last night. Hx of kidney stones. pn (R) of naval.
R	O: WNWD ♂ A&O x3 LBM last night, normal.
12/65 B/P	UA - Spec grav - 1.015 Blood - Neg
T	protien - Neg Ketones - Neg
SPO2	pH - 5.0 Leukocytes - Neg
	Abd - neg rigidity, neg rebound pn, positive active bowel sounds all quadrants
Meds	A: Dehydration
	P 1000 mL NS I.V. (L) arm @ 1130hrs.
All	↑ fluid intake, FU PRN.
	Pt. states he feels better.
Tob	

(b)(6)

(b)(6)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

IENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)	REGISTER NO.	WARD NO.
SN: Compound # : 1		

ACLU-RDI 5484 p.750

ACLU DDI CID ROIS 38956

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record 000079

STANDARD FORM 600 (REV. 6-97)

Prescribed by GSA/ICMR

Exhibit 2

PREVIOUS EDITION IS USABLE AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

DETAINEE HEALTH AND MEDICAL RECORD OF QUALITY ASSURANCE SCREE
(SF600 OVERPRINT, VER 1.1, IAW AR 190-8)

~~EXAMINATION PER AR 190-8 6-6~~	~~DATE~~	~~TRAVEL GO/~~ OR NO-GO	~~CORRECTED~~ TO GO	~~COMMENT~~
~~MEDICAL EXAMINATION WAS COMPLETED~~	07 DEC 2004	GO		
~~DENTAL SCREENING WAS COMPLETED~~	07 DEC	GO		
CHEST X-RAY/TB SCREEN WAS COMPLETED				
NUTRITION SCREENING WAS COMPLETED				
BEHAVIORAL HEALTH SCREENING WAS COMPLETED	9 DEC	GO		

LIMITATIONS

ACTIVITY RESTRICTIONS: NO
~~DIET RESTRICTION:~~ NO
OTHER RESTRICTIONS: NO

TRAVEL (GO/NO GO) =GO=
(IF NO-GO LIST REASONS)

(b)(6)

PROVIDER SIGNATURE AND DATE

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

ISN 166576 CAMP
NAME Hamid, Ahmed Ibrahim
DOB 1975 AGE 29 SEX M

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FPMR (41 CFR 201-9.202)

Eye Health Questionnaire

16657b

هل عندك اي مشكلة في نظرك ؟

1. Are you having any problems with you vision? Yes No / نعم لا

هل تلبس نظارات ؟

2. Do you wear glasses? Yes No / نعم لا

If yes: لو كانت الاجابة بنعم

A. To see better at هل تستطيع ان ترى أفضل Distance Near / من بعيد من قريب

هل معك نظاراتك الآن ؟

B. Do you have your glasses with you? Yes No / نعم لا

هل عندك الم شديد في عيونك

3. Are you having any significant eye pain? Yes No / نعم لا

هل حدث لك أي اصابة او عملية جراحية ؟

4. Have you had any recent injury/surgery to your eyes? Yes No / نعم لا

هل حدث لك فجأة قصور او نقصان في النظر ؟

5. Have you had a recent sudden decrease in your vision? Yes No / نعم لا

هل تأخذ أي أدوية لعيونك

6. Do you take any medicine for your eyes? Yes No / نعم لا

If yes: لو كانت إجابتك بنعم أجب على الأسئلة التالية

A. Do you have it here with you? Yes No / نعم لا

هل لديك الدواء الآن ؟

B. Do you know what it is called or for? Yes No / نعم لا

هل تعرف أسم هذا الدواء ؟

Abdomen / Male 166574

TRIAGE
Date 3 July 05 TIME 0115 emergent (urgent) non-urgent

NAME: ATAWI, AHMED, ISMAIL
D.O.B 1975 AGE: 30
HISTORIAN: X patient __paramedics __family
ARRIVAL MODE: __car __EMS __police WALKED
CP: __none
IMMUNIZATIONS: current / ^not current / referral

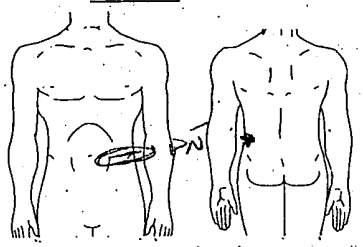
TREATMENT PTA __see EMS report __IV __O_2
Medications:
Interventions:
] none

CHIEF COMPLAINT ABDOMINAL PN w/ Lower EXTREMITY
started ____ hrs / days ago INFLAMATION

__urinary problems
(nausea / vomiting x
__diarrhea
__fever / chills
__back pain
__blood in vomit
__blood in stool
__penile discharge
__last BM
__chemical exposure

Quality:
pain"
ching
lull
urning
ramping
harp
tabbing
ullness

location:



__migration (show migration:)

PAIN LEVEL current: 7 / 10 maximum: 10 / 10

VITALS time: 0103
BP 109 / 68 P 105 RR ____ temp 98.8 TM O R Ax
Height ____ Weight ____ kg
O_2 Sat% 98 RA / O_2 ____ GCS ____

ALLERGIES X NKDA / PCN / ASA / sulfa / latex

MEDS X none __see med list __OTC __vitamins
__herbal preparations

PAST HX X negative
__kidney stone / heart disease / HTN / diabetes *insulin*
__family history of heart disease
__past surgeries *none*
__sexually active
__smoker / drugs / alcohol
__^TB exposure / symptoms
__^has been physically hurt or threatened by someone close

RN Signature ____

TIME TO ROOM:
INITIAL ASSESSMENT TIME 0120 ROOM ETR.

GENERAL APPEARANCE
__no acute distress (__mild / moderate / severe distress
L alert __anxious / decreased LOC

FUNCTIONAL / NUTRITIONAL ASSESSMENT
L appears well nourished __^obese / malnourished
__independent ADL __^assisted / total care

RESPIRATORY
✓ no resp distress __mild / moderate / severe distress
L nml breath sounds __wheezing / crackles / stridor
__decreased breath sounds
__retractions / accessory muscle use

CVS
__regular rate X tachycardia / bradycardia / irrg rhythm
X pulses strong __pulse deficit
X skin warm & dry __cool / diaphoretic
X nml cap refill __pale / cyanotic
__cap refill greater than 2 seconds

ABDOMEN
__nml inspection X tenderness / guarding / rebound
__non-tender __distention
X bowel sounds present __bowel sounds *hypoactive / hyperactive*
__stool heme neg. __stool heme pos.

GU
X no discharge __penile discharge
X nml scrotal exam __scrotal swelling / redness
__hesitancy / urgency

NEURO
X oriented x3 __disoriented to *person / place / time*
X moves all extremities __confused
__weakness / sensory loss

ADDITIONAL FINDINGS
① Pt ambulated TO TIF WITH ABDominal & Lower EXTREMITY INFLAMMATION
② L & R (A) PITTEDEMA IS PRESENT ↑ SWELLING. ABD INSPECTION with mild guarding and localize PN LATERAL MID SECTION OF (L) SIDE. PN TRAVELS TO MID AXICHRY PT.
③ Drew Bloods (CHEM 12) (HEMO)
④ Pt IS ALERT AND Cooperative!

Nurse Signature ____

^ protocol available

SASH ED Camp Bucca
EMERGENCY NURSING RECORD

Ahmed Ismail Atawi

AUTHORIZED FOR LOCAL REPRODUCTI

MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7 July	NUTRITION RISK SCREENING
	S/O: ACTIVE DUTY CONTRACTOR (DETAINEE) CIVILIAN ING
	WARD: ICW BED NUMBER: 12 DX: Anemia, Splenom Malaria
	AGE: 30 GENDER: (M) F HT: 70" WT: 150 BMI: 21
	DIET: High Protein, ensure & meals
	TOLERATING DIET: no milk products
	A/P:
	NUTRITION RISK:
	Patient determined to be at low risk; will re-screen in one week.
	Patient determined to be at nutrition risk secondary to:
(b)(6)	Further intervention by RD within 48 hours.
	RD recommended
	Mask RD Fu BID
9 July	Reassessed/Fu (b)(6) (b)(6) NCD, 344th Combat Support Hospital

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
Camp Buca			
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) REGISTER NO. WARD NO.

166576 Ahmed

CHRONOLOGICAL RECORD OF MEDICAL CAR
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V2.0
Exhibit 2

0073-05-CID579-40022

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE / SEX / SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CXR	M	ICW	166576
	FILM NO.		PREGNANT ☐ YES ☑ NO
	REQUESTED BY (Print) (b)(6)		TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR		DATE REQUESTED 4 JULY 2005

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

(B) LE edema

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)
July 04 2005		

RADIOLOGIC REPORT

nl cardiac shadow

nl lung fields

nl CXR

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

166576

Bed #12

Atawi Ahmed

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE (b)(6)

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

Exhibit 2

NSN 7540-01-165-7294 519-3(

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

Abdominal Xray
Flat/upright

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
	M	166576	ICW I	166576

FILM NO.

PREGNANT ☐ YES ☑ NO

REQUESTED BY (Print) (b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

DATE REQUESTED

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

abd pain

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)
July 04 2005		

RADIOLOGIC REPORT

few air fluid levels
no obstruction
nl xray eval

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

166576

ICW Bed #12

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIG (b)(6)

ID ROIS 38962
000085

ACLU-RDI 5494 p.81

Atawi Ahmed

RADIOLOGY CONSULTATION REQUEST/REPORT
2 — PHYSICIAN

STANDARD FORM 519-B (8-83) Exhibit
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

TASK FORCE MED 11L [redacted] RATORY — **Camp Bucca Internment Facility SASH, Iraq**

[redacted] ORATORY FORM — **(Subject to Privacy Act of 1974)**

LAST, FIRST, MI. (Or Hospital ID #): 146576 | Male / Female | SSN or ISN: 146576 | Signs and Symptoms: Guyton Quadriplegic

Physician: | Ward: ICU | STAT / Routine | Specimen Collection Date & Time: | Lab Use Only Initials: | Lab Use Only D&T:

Drawn by: | Bed:

Chemistry (i-STAT): Synnge / Green Top — Bld Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 ulU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests: (Consult with Lab Prior to Submitting)

Abdi Ahmed

Chemistry (Piccolo Analyzer): Green Top — Chem 12 MetLyte BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB	<1.0	3.3-5.5 g/dL
ALP	103	26-184 U/L
ALT	13	10-47 U/L
AMY	13	14-110 U/L
AST	28	11-38 U/L
Tbil	0.5	0.2-1.6 mg/dL
BUN	11	7-22 mg/dL
Ca	7.7	8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL	98	98-109 mmol/L
TCO2	28	18-33 mmol/L
Creat	1.1	0.6-1.3 mg/dL
GGT	6	5-65 U/L
Glu	100	73-118 mg/dL
K	4.2	3.3-4.9 mmol/L
TProtein	4.1	6.4-8.1 g/dL
Na	128	138-145 mmol/L
Phos	4.2	2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top — CBC / Manual Differential

TEST	RESULT	REF. RANGE
WBC	12.2	4.8-10.8 x10(3)/uL
RBC	4.25	4.2-6.1 x10(6)/uL
Hgb	8.8	12.0-18.0 g/dL
Hct	27.9	M: 42.0-52.0%
		F: 37-47%
MCV	65.6	80.0-99.0 fl
MCH	20.6	27.0-31.0 pg
MCHC	31.4	33.0-37.0 g/dL
Plt	568	130-400 x10(3)/uL
LY%	19.3	20.0-44.0%
LY#	2.4	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells
RBC Abn Morph:	
Plt Abn Morph:	
WBC Abn Morph:	

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S	Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel: Includes Gram Stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

Exhibit 2

TASK FORCE MED 115 LABOR — LABORATORY FORM — 0073-05-CID579-40022
Camp Bucca Internment Facility — (Subject - Privacy Act of 1974)

Need IV Tube For Send Out — Hep ASCA

ST, FIRST, MI. (Or Hospital ID #): IWAI, AHMED ISMAIL
ysician: Ward: ICW
awn by: Bed: #12
ime:
Signs and Symptoms: Anemia H/o Spleenomegaly
Lab Use Only — Initials: (b)(6)
Lab Use Only — D&T: 5 Jun 06 07 05

Chemistry (i-STAT) Syringe / Green Top
Bld Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
H		7.35-7.45
CO2		35-45 mmHg
O2		80-100 mmHg
CO2		18-33 mmol/L
CO3		22-26 mmol/L
O2		95-99%
Eecf		(-2) - (+3)
actate		0.90-1.70 mmol/L
lucose		73-118 mg/dL
reat		0.6-1.3 mg/dL

Urinalysis

olor		Straw/Yellow
larity		Clear
Glucose		Negative
ilirubin		Negative
etone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other: Urine for Na+	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 uIU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests (Consult with Lab Prior to Submitting)

Chemistry / Green Top — Renal

TEST	RESULT	REF. RANGE
ALB		/dL
ALP		U/L
ALT		/L
AMY		U/L
AST	27	11-38 U/L
Tbil	0.5	0.2-1.6 mg/dL
BUN	10	7-22 mg/dL
Ca	7.4 L	8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
LFT		F: 30-190 U/L
CL	98	98-109 mmol/L
TCO2	29	18-33 mmol/L
Creat	0.9	0.6-1.3 mg/dL
GGT	5	5-65 U/L
Glu	85	73-118 mg/dL
K	4.2	3.3-4.9 mmol/L
TProtein	3.4 L	6.4-8.1 g/dL
Na	129	138-145 mmol/L
Phos	4.3 H	2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Alpha fetoprotein Level
Hepatitis A, B, C, D

Hematology (Coulter) Purple Top
CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC	12.2	4.8-10.8 x10(3)/uL
RBC	3.96	4.2-6.1 x10(6)/uL
Hgb	8.1	12.0-18.0 g/dL
Hct	25.8	M: 42.0-52.0%
		F: 37-47%
MCV	65.2	80.0-99.0 fl
MCH	20.3	27.0-31.0 pg
MCHC	31.2	33.0-37.0 g/dL
Plt	536	130-400 x10(3)/uL
LY%	21.8	20.0-44.0%
LY#	2.7	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells
RBC Abn Morph:	
Plt Abn Morph:	
WBC Abn Morph:	

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate	23	0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT	14.2	7.0-14.0 sec
APTT	47.5	21.0-50.0 sec
INR	1.4	0.5-1.5/therap 2-3
ESR		

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

TASK FORCE MED [redacted] LABORATORY — Camp Bucca Internment Facility SASH, Iraq

LABORATORY FORM (Subject to Privacy Act of 1974)

LAST, FIRST, MI. (Or Hospital ID #): ATAWI, AHMED ISMAIL
Physician: (b)(6) Ward: ETR
Drawn by: (b)(6) Bed:
Male / Female / STAT / Routine
SSN or ISN: 166576
Specimen Collection Date & Time: 4 July '05, 305 Hrs
Signs and Symptoms:
Lab Use Only Initials: (b)(6)
Lab Use Only D&T: 4JUL05 (b)(6)

Chemistry (i-STAT): Syringe / Green Top — Bd Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 ulU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests: (Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top — Chem 12 MetLyte8 BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN		7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL		98-109 mmol/L
TCO2		18-33 mmol/L
Creat		0.6-1.3 mg/dL
GGT		5-65 U/L
Glu		73-118 mg/dL
K		3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na		138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top — CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/u
RBC		4.2-6.1 x10(6)/u
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%) 59	Mono(4-10%) 10
Bands(1-10%) 5	Eos(0-4%) 5
Lymph(20-44%) 19	Baso(0-2%)
Atyp Ly 2	Immature cells

RBC Abn Morph: Mod Anisocytosis Mod hypochromic, slt microcytes, slt poi

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate	20	0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT	10.0	7.0-14.0 sec
APTT	33.9	21.0-50.0 sec
INR	1.0	0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container

Fluid Panel Includes Gram Stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

TASK FORCE MED 115 LABORATORY
Camp Bucca Internment Facility SASH, Iraq

LABORATORY FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. (Or Hospital ID #): ATAWI, AHMED 166576 ISMAIL
Physician: (b)(6)
Drawn by: (b)(6)
Ward:
Bed: ICW
Male / Female / STAT / Routine
SSN or ISN: 166576
Specimen Collection Date & Time: 2005 07 06 1415hrs
Signs and Symptoms: R/O Splenomegaly
Lab Use Only Initials: (b)(6)
Lab Use Only D&T: 6JUL05 1845

Chemistry (i-STAT): Syringe / Green Top
Bld Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 ulU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional Other Requests
(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top
Chem 12 Mod Lyte8 BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB	2.0	3.3-5.5 g/dL
ALP	101	26-184 U/L
ALT	17	10-47 U/L
AMY	17	14-110 U/L
AST	23	11-38 U/L
Tbil	0.5	0.2-1.6 mg/dL
BUN	11	7-22 mg/dL
Ca	6.4	8.0-10.3 mg/dL
Chol	86	100-200 mg/dL
CK		M: 39-380 U/L
Serum Iron		~~F: 30-100 U/L~~
CL	98	98-109 mmol/L
TCO2		18-33 mmol/L
Creat	1.3	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	106	73-118 mg/dL
K	4.0	3.3-4.9 mmol/L
TProtein	3.6	6.4-8.1 g/dL
Na	131	138-145 mmol/L
Phos	4.0	2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
~~IG~~ BMP		~~60-160 mg/dL~~
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top
CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC	13.5	4.8-10.8 x10(3)/uL
RBC	3.93	4.2-6.1 x10(6)/uL
Hgb	8.2	12.0-18.0 g/dL
Hct	26.6	M: 42.0-52.0%
TEBC		~~F: 37-47%~~
MCV	67.8	80.0-99.0 fl
MCH	21.0	27.0-31.0 pg
MCHC	30.9	33.0-37.0 g/dL
Plt	530	130-400 x10(3)/uL
LY%	20.6	20.0-44.0%
LY#	2.8	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph: normochromic microcytosis, microcytosis, Retic Count, ovalocytes, schistocytes
~~Plt Abn Morph:~~ Stomatocytes, target cells
*parasite seen in RBCs
WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container
Fluid Panel Includes: Gram stain,

Exhibit 2

TASK FORCE MED 115 LABORATORY
Camp Bucca Internment Facility SASH, Iraq

LABORATORY FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. (Or Hospital ID #): 4TANE, AHMED 166576 ISMAEL
Physician: (b)(6) Ward:
Drawn by: (b)(6) Bed: FLW

☒ Male ☐ Female ☐ STAT ☒ Routine

SSN or ISN: 166576
Specimen Collection Date & Time: 20050706 1415HR

Signs and Symptoms: R/O SEPTICEMIA/SEPSIS
Lab Use Only Initials: (b)(6) Lab Use Only: 2072

Chemistry (i-STAT) Syringe / Green Top
Bld Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 ulU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional Special Requests:
(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top
Chem 12 MetLyte8 BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN		7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL		98-109 mmol/L
TCO2		18-33 mmol/L
Creat		0.6-1.3 mg/dL
GGT		5-65 U/L
Glu		73-118 mg/dL
K		3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na		138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top
CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/uL
RBC		4.2-6.1 x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin	POS	No Plasmodium Seen
Thick	POS	No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container
Fluid Panel Includes: Gram stain,

TASK FORCE MED 115 LABORATORY
Camp Bucca Internment Facility SASH, Iraq

LABORATORY FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. (Or Hospital ID #): ATAWI, AHMED ISMAIL

Physician: (b)(6)

Drawn by: (b)(6)

Ward: FTR

Bed:

Male / Female

SSN or ISN: 166576

STAT / Routine

Specimen Collection Date & Time: 4 July 05, 305 AM

Signs and Symptoms:

Lab Use Only Initials: CJ

Lab Use ONLY D&T: 4JUL05

Chemistry (i-STAT): Syringe / Green Top
Bld Gas, Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 ulU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests:
(Consult with Lab Prior to Submitting)

Atawi Ahmed

Chemistry (Piccolo Analyzer): Green Top
Chem 12 Met Lyte 8 BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN		7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL		98-109 mmol/L
TCO2		18-33 mmol/L
Creat		0.6-1.3 mg/dL
GGT		5-65 U/L
Glu		73-118 mg/dL
K		3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na		138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple
CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)
RBC		4.2-6.1 x10(6)/
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/ul
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	59	Mono(4-10%)	10
Bands(1-10%)	5	Eos(0-4%)	5
Lymph(20-44%)	19	Baso(0-2%)	
Atyp Ly	2	Immature cells	

RBC Abn Morph: Mild Anisocytosis, mild hypochromic, slt microcytes, slt poi

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate	20	0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT	10.0	7.0-14.0 sec
APTT	33.9	21.0-50.0 sec
INR	1.0	0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.3 ng/mL

Body Fluid Panel / Sterile Container

Fluid Type: Gram stain, WBC & RBC count, WBC differential

TASK FORCE MED 115 LABORATORY
Camp Bucca Internment Facility SASH, Iraq

LABORATORY FORM
(Subject to Privacy Act of 1974)

ST, FIRST, MI, (Or Hospital ID #): 146576
sician: Ward: ER
wn by: Bed:

Male / Female
SSN or ISN: 146576
STAT / Routine
Specimen Collection Date & Time:

Signs and Symptoms: Gunshot Wound
Lab Use Only Initials:
Lab Use Only D&T:

Chemistry (i-STAT): Syringe / Green Top
Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
		7.35-7.45
CO2		35-45 mmHg
O2		80-100 mmHg
HCO2		18-33 mmol/L
HCO3		22-26 mmol/L
O2		95-99%
Becf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 ulU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests:
(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top
Chem 12 Met Lyte BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB	41.0	3.3-5.5 g/dL
ALP	103	26-184 U/L
ALT	13	10-47 U/L
AMY	13	14-110 U/L
AST	28	11-38 U/L
Tbil	0.5	0.2-1.6 mg/dL
BUN	11	7-22 mg/dL
Ca	7.7	8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL	98	98-109 mmol/L
TCO2	28	18-33 mmol/L
Creat	1.1	0.6-1.3 mg/dL
GGT	6	5-65 U/L
Glu	108	73-118 mg/dL
K	4.2	3.3-4.9 mmol/L
TProtein	6.1	6.4-8.1 g/dL
Na	128	138-145 mmol/L
Phos	4.2	2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top
CBC / Manual Differential

TEST	RESULT	REF. RANGE
WBC	12.2	4.8-10.8 x10(3)/uL
RBC	4.25	4.2-6.1 x10(6)/uL
Hgb	8.8	12.0-18.0 g/dL
Hct	27.9	M: 42.0-52.0%
		F: 37-47%
MCV	65.6	80.0-99.0 fl
MCH	20.6	27.0-31.0 pg
MCHC	31.4	33.0-37.0 g/dL
Plt	568	130-400 x10(3)/uL
LY%	19.3	20.0-44.0%
LY#	2.4	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container
Fluid Panel Includes: Gram Stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

Ataul Ahmed

Exhibit 2

TASK FORCE MED 115 LABORATORY
Camp Bucca Internment Facility SASH, Iraq

LABORATORY FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. (Or Hospital ID #): ATAWI, AHMED ISMAIL
Physician: (b)(6) Ward: ICW
Drawn by: (b)(6) Bed: 12

✓ Male / Female
SSN or ISN: 166576
STAT / ✓ Routine
Specimen Collection Date & Time: 8 JULY 2005 1100

Signs and Symptoms: Malaria/Std Retention
Lab Use Only Initials: (b)(6)
Lab Use Only D&T: 8 July 05 1414

Chemistry (i-STAT): Syringe / Green Top
Bld Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 ulU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests: (Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top
Chem 12 MetLyte8 BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB	<1.0	3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN	10	7-22 mg/dL
Ca	7.3	8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL	96	98-109 mmol/L
TCO2	27	18-33 mmol/L
Creat	0.6	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	78	73-118 mg/dL
K	4.3	3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na	123	138-145 mmol/L
Phos	3.6	2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top
CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/uL
RBC		4.2-6.1 x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container
Fluid Panel Includes: Gram stain,

Exhibit 2

TASK FORCE MED 115 LABORATORY
Camp Bucca Internment Facility SASH, Iraq

LABORATORY FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. (Or Hospital ID #)		Male	SSN or ISN:	Signs and Symptoms:	
Atawi Ahmed		Female	166576	Malaria	
Physician:	Ward: 10 W	STAT	Specimen Collection Date & Time:	*Lab Use Only* Initials:	*Lab Use Only* D&T:
Drawn by (b)(6)	Bed: 12	Routine	09 Jul 05 0530		

Chemistry (i-STAT): Syringe / Green Top
Bld Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 ulU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests:
(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top
Chem 12 MetLyte8 BMP Liver Lipid Renal

TEST	RESULT	REF. RANGE
ALB	<1.0	3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN	10	7-22 mg/dL
Ca	6.7	8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL	97	98-109 mmol/L
TCO2	30	18-33 mmol/L
Creat	0.8	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	85	73-118 mg/dL
K	4.2	3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na	128	138-145 mmol/L
Phos	4.0	2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top
CBC Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/uL
RBC		4.2-6.1 x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

~~WBC Abn Morph:~~ (Serum Renal)

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel: Gram Stain, WBC & RBC count, WBC differential and Meningitis Panel (CSF only) — Specify Container / Fluid Panel Includes:

Exhibit 2

TASK FORCE MED 115 LABORATORY
Camp Bucca Internment Facility SASH, Iraq

LABORATORY FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. (Or Hospital ID #): ATANI Ahmed
Physician: Ward: ICW
Drawn by (b)(6) Bed: 12
Male / Female / STAT / Routine
SSN or ISN: 166579
Specimen Collection Date & Time: 11July05
Signs and Symptoms: Malaria
Lab Use Only Initials (b)(6)
Lab Use Only D&T: 11July05 0800

Chemistry (i-STAT): Syringe / Green Top
Bld Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 ulU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests:
(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top
Chem 12 / MetLyte8 / CMP / Liver / Lipid / Renal

TEST	RESULT	REF. RANGE
ALB	1.0 L	3.3-5.5 g/dL
ALP	155 H	26-184 U/L
ALT	11	10-47 U/L
AMY	15	14-110 U/L
AST		11-38 U/L
Tbil	.6	0.2-1.6 mg/dL
BUN	10	7-22 mg/dL
Ca	7.0 L	8.0-10.3 mg/dL
Chol	82 L	100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL	95	98-109 mmol/L
TCO2	33	18-33 mmol/L
Creat	9.03 L	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	93	73-118 mg/dL
K	4.1	3.3-4.9 mmol/L
TProtein	4.1 L	6.4-8.1 g/dL
Na	130	138-145 mmol/L
Phos	4.6 H	2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top
CBC / Manual Differential

TEST	RESULT	REF. RANGE
WBC	13.6 H	4.8-10.8 x10(3)/uL
RBC	4.17	4.2-6.1 x10(6)/uL
Hgb	8.8 L	12.0-18.0 g/dL
Hct	27.4 L	M: 42.0-52.0%
		F: 37-47%
MCV	65.5 L	80.0-99.0 fl
MCH	20.4 L	27.0-31.0 pg
MCHC	30.4 L	33.0-37.0 g/dL
Plt	584 H	130-400 x10(3)/uL
LY%	25.2	20.0-44.0%
LY#	3.4 L	0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph: 2+aniso, parasites seen 1+target, 3+hypochromia, 3+poikilo, 1+
Plt Abn Morph:
WBC Abn Morph:

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container
Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

Exhibit 2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
20 Jul 05	Internal medicine feels well. Concerned about Scrotal edema. AF, VSS PRESENT: pale mucosa Chest: clear Heart: NL S1S2 Abd: Soft GU: moderate Scrotal/penile edema. Ext: 2+ pitting edema Imp: Advanced Stage, chronic malaria c hepatosplenomegaly, hypoalbumin Completing course of doxycycline Plan: 1) Continue high protein diet, free fluid restriction 2) Lasix prn for edema. (b)(6)
21 July 05	Nutrition Therapy FU: Cont c hyponatremia, hypochloremia hypoalbuminemia, +2 lower extremity edema. Refuses Ensure Plus, changed to Tpro fruit shake refuses this. Today changed to Promod fortified soup & Chicken broth (wanted something hot rather than cold) Receives 2 eggs @ AM, 2 portions pulse/meat stew @ lunch & additional @ dinner. Receiving FeSO4 & Vit C, stool received add. blood products 14 July. Pt remains @ high nutrition risk. Plan: Provide Protein fortified foods/Blends & Tprotein diet. Encourage intake. (b)(6)

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
22 Jul 05 0830	Medicine AF, BP 100/70, HR 115 Chest: Clear Heart: Tachy reg rhythm Abd: Soft, splenomegaly Ext: 2+ pitting edema Bedside (16.6)/(25.6) <407 124/3.9/23/1.0 <92 Imp Advanced Stage Chronic malaria Hepatosplenomegaly, hypoalbuminemia with 2° hyponatremia minimal improvement after 2 weeks. - We are retreating malaria for possible resistance and hepatic reservoirs. Received Mefloquin last night. - Continue nutrition supplements and careful observation.
23 Jul 05	Medicine Called to see pt emergently at 0930. On arrival he appeared listless, cool and clammy. Was apparently in heat (outside) for 30 mins. Possible seizure activity described. Exam Awake, responsive Data ECG: ST, Ø ischemia Chest: clear anteriorly CXR: Hyperventilation, Ø inf/trades Heart: Tachy, reg rhythm labs ABG 7.26/161/13/99% AGAP 24 Abd: distended, but soft 13.3/(33)/(541) 130/92/18 (5.3)/14/(1.5) (48) Ext: Trace pulses, 2+ edema Cool Intravascular Imp Volume depletion, lactic acidosis Renal insufficiency, hypoglycemia Pla Transfered to ICU. Central access, foley Aggressive volume repletion

AST	ALT	TBG	TP	Alb	ALP	PT	INR	Myo	TN
103	41	22	3.7	1.0	(154)	30.4	3.0	>500	<0.04

TASK FORCE MED 115 LABORATORY
Camp Bucca Internment Facility SASH, Iraq

LABORATORY FORM
(Subject to Privacy Act of 1974)

LAST, FIRST MI (Or Hospital ID #): Hawi Ahmed I
Physician:
Drawn by:
Ward: icw
Bed: 12
Male / Female
SSN or ISN: 166576
STAT / Routine
Specimen Collection Date & Time: 14 July 05 0530
Signs and Symptoms: Malaria
Lab Use Only Initials:
Lab Use Only D&T:

Chemistry (i-STAT): Syringe / Green Top
Bld Gas - Bld Gas w/Lact - Glu - Crea

TEST	RESULT	REF. RANGE
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
SO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top

TSH		0.25 - 5 uIU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests
(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top
Chem12 / MetLyte / CRP / Liver / Lipid / Renal

TEST	RESULT	REF. RANGE
ALB	<1.0	3.3-5.5 g/dL
ALP	158	26-184 U/L
ALT	21	10-47 U/L
AMY	11	14-110 U/L
AST	22	11-38 U/L
Tbil	0.6	0.2-1.6 mg/dL
BUN	9	7-22 mg/dL
Ca	6.7	8.0-10.3 mg/dL
Chol	78	100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL	99	98-109 mmol/L
TCO2	23.0	18-33 mmol/L
Creat	0.7	0.6-1.3 mg/dL
GGT		5-65 U/L
Glu	103	73-118 mg/dL
K	3.9	3.3-4.9 mmol/L
TProtein	3.4	6.4-8.1 g/dL
Na	132	138-145 mmol/L
Phos	3.1	2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests

Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top
CBC / Manual Differential

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10(3)/uL
RBC		4.2-6.1 x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47%
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400 x10(3)/uL
LY%		20.0-44.0%
LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells
RBC Abn Morph:	
Plt Abn Morph:	
WBC Abn Morph:	

Malaria Smear / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top

Hb S		Negative

Coagulation / Blue Top (3.2%)

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3

Cardiac Panel / Purple Top

Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid Panel / Sterile Container
Fluid Panel Includes: Gram Stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

TASK FORCE MED 115 LABC
Camp Bucca Internment Facility S)

LABORATORY FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. (Or Hospital ID #): ATWAN AHMED KHAEL
Male / Female
SSN or ISN: 166576
Signs and Symptoms: R/O MALARIA
Physician: (b)(6) Ward: CW
Drawn by: (b)(6) Bed: #12
STAT / Routine
Specimen Collection Date & Time: 14 July 05 / 1045hrs
Lab Use Only Initials: (b)(6)
Lab Use Only D&T: 14 July 05 / 1048

Chemistry (I-STAT): Syringe / Green Top		
Bld Gas - Bld Gas w/Lact - Glu - Crea		
TEST	RESULT	REF. RANGE
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-100 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
Lactate		0.90-1.70 mmol/L
Glucose		73-118 mg/dL
Creat		0.6-1.3 mg/dL

Urinalysis		
Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic	
WBC:	EPI:
RBC:	Mucus:
Bacteria:	Yeast:
Casts:	Crystals:
Other:	

Special Chemistries / Red or Tiger Top		
TSH		0.25 - 5 ulU/ml
FT4		9 - 20 pmol/L
FT3		4.0 - 8.3 pmol/L
T4		60 - 120 nmol/L
T3		0.92 - 2.33 nmol/L
HIV		Negative

Additional / Other Requests
(Consult with Lab Prior to Submitting)

Chemistry (Piccolo Analyzer): Green Top		
Cham 12 MetLyte8 BMP Liver Lipid Renal		
TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dL
ALP		26-184 U/L
ALT		10-47 U/L
AMY		14-110 U/L
AST		11-38 U/L
Tbil		0.2-1.6 mg/dL
BUN		7-22 mg/dL
Ca		8.0-10.3 mg/dL
Chol		100-200 mg/dL
CK		M: 39-380 U/L
		F: 30-190 U/L
CL		98-109 mmol/L
TCO2		18-33 mmol/L
Creat		0.6-1.3 mg/dL
GGT		5-65 U/L
Glu		73-118 mg/dL
K		3.3-4.9 mmol/L
TProtein		6.4-8.1 g/dL
Na		138-145 mmol/L
Phos		2.2-4.5 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Miscellaneous / Rapid Tests		
Mono		Negative
RPR		Negative
Drug Screen		Negative
HCG		Negative
H. pylori		Negative
ETOH/Alc.		Negative
Strep A		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile		Negative
O&P		No Ova / Parasite
Occult Bld		Negative
Wet Mount		Negative
KOH		Negative

Hematology (Coulter): Purple Top		
TEST	RESULT	REF. RANGE
WBC	17.0	4.8-10.8 x10(3)/uL
RBC	3.60	4.2-6.1 x10(6)/uL
Hgb	7.5	12.0-18.0 g/dL
Hct	24.1	M: 42.0-52.0%
		F: 37-47%
MCV	66.9	80.0-99.0 fl
MCH	20.9	27.0-31.0 pg
MCHC	31.2	33.0-37.0 g/dL
Plt	537	130-400 x10(3)/uL
LY%	15.8	20.0-44.0%
LY#	2.7	0.7-4.3 x10(3)/uL

Differential	
Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph: parasites seen, 3+ poikilocytes, 3+ microcytic, 2+ hypochromasy, 1+ target,
Plt Abn Morph:
WBC Abn Morph:

Malaria Smear / Purple Top		
Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top		
Sed Rate		0-20 mm at 1 hour

Hemoglobin S / Purple Top		
Hb S		Negative

Coagulation / Blue Top (3.2%)		
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Cardiac Panel / Purple Top		
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Troponin		NEG / 0.0-0.4 ng/mL

Body Fluid (CSF) Specimen Container
Fluid Panel Includes: Gram stain, WBC & RBC count, WBC differential, and Meningitis Panel (CSF only)

Exhibit 2

DICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

15 Jul 05

medicine

Developed worsening respiratory distress yesterday afternoon leading to tracheal intubation & mechanical ventilation

Currently sedated, on vent and pressor support

Exam/Data: Afibrile, BP 80/50, HR 130, RR 18

Neck: Supple

Chest: ↓ BS (B) bases

Heart: Tachy, reg rhythm

Abd: Soft distended, edematous. HSM

Ext: 3+ diffuse pitting edema

infusions: Dopamine 10mcg/kg/min; Diprivan 30cc/hr; D5LR 150cc/hr

Vent: FiO2 80% TV 700, VR 14

CXR: (R) Pleural effusion

Labs: 9.6 / 24.7 \ 492 | (126/93/28) / (52) (17) 1.1 \ 107 | AH (127) | AP (185) | Tb 0.6 | Alb KI.0

Imp: Hepatic failure presumed due to chronic malaria, now superimposed sepsis. Critically ill.

Plan: 1) ID: D#2 Ceftriaxone. No cultures available. 10 day course planned. GI is assumed source (bowel edema, ? megacolon)

Completed 2 courses of Rx for malaria. Residual parasites on smear

2) CV: Pressor support with dopamine. maintain CVP ≈ 15, IVFs / lasix prn

3) Renal: Oliguric renal failure. lasix prn to keep UOP

4) Heme: HCT stable. Transfuse if HCT falls to ≤ 21

5) GI/Liver: Supportive care. Consider tube feeds in 48 hrs.

6) Pulm: Continue mech. ventilation. Titrate Ativan/Versed to Ativan.

(b)(6)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	INTAINEE
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO	REGISTER NO. / WARD ICU

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

166576

ATAWI, Ahmed Ismael

CHRONOLOGICAL RECORD OF MEDICAL
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR 141 CFR 201.45.101

Exhibit 2

7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
24 Jul 05	(S) Feeling better - less dyspneic - wants to go back to ICW
	Less diaphoretic - hungry (?)
	(O) BP 75/48 Temp 94 Ax P 116 R 24 Pulse ox 100% on O2
	Normal RRR S1 S2 lungs - basilar crackles - o/w clear
	Abd - absent bowel sounds, but not board-like
	Extr - cool, thready pulses In - 2200 Out - urine 70 cc NG 300 cc
	Labs: K+ 5.7 Na+ 125 Glu 169 (4 Amps of D50 in past 24°)
	WBC 14.6 H/H 9.3/30.0 TCO2 17 (up from 11)
	Alb < 1.0 Ca+ 7.3 BUN/Creat 25/1.3
	(A/P) Sepsis/UGI - IVF, Albumin, Rocephin
	Hypoglycemia - D50, monitor Glucose, D5
	Hyponatremia - D to NS from ½ NS
	Hypoalbuminemia/pedal edema
	Oliguria/ARF - high volume fluid replacement
	Lactic acidosis ? sepsis - consider HCO3 if CO2 < 14
	Hyperkalemia - Kayexalate if > 6.0
	Malaria - on Mefloquine and Doxycycline
	Atelectasis - encourage deep breaths, O2 to keep sats ≥ 95%
	Ileus - NG decompression - ✓ KUB
	Pregnant guarded - Command element aware
*	Add: Case discussed c (b)(6), GI at Abu and
	c (b)(6), ID @ WRH

(b)(6)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)		REGISTER NO.	WARD

CHRONOLOGICAL RECORD OF MEDICAL Medical Record

STANDARD FORM 600 (REV. 10-87)
Prescribed by GSA/ICMR
FIRMR 141 CFR 201-9.202-1

MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
26 Jul 05	Medicine Remains Critically ill. Sedated, intubated, mechanically ventilated Exam Tm 100, HR 130s, BP 91/45 CVP 12-14 NECK: Supple Chest: clear anteriorly Heart: Tachy, reg rhythm Abd: distended, edematous, soft EXT: 4+ edema Vent FiO2 35%, Vt 700, VR 14 Infusions norepi 25mcg/min D5 LR 50cc/hr Labs (233)/25.9 <452 132/5.4/19/33/1.3/89 Imp: GI Sepsis with underlying chronic malaria & hepatic failure. Remains pressor dependent and mechanically ventilated. Plan 1) ID: D#4 Ceftriaxone. D#2 flagyl. Increased leukocytosis noted. If this continues, will add additional gm(-) coverage. 2) CV: Continue norepi @ 25mcg/min. Stable BP over past 24hrs. 3) Renal: Oliguric renal failure. Add scheduled lasix dose 4) Heme: HCT 26% and stable. 5) GI/liver: Hepatic failure, gastroparesis with PD NG. Out put NOT ready for tube feeds. Continue Zantac 6) Pulm: Continues mechanical ventilation. NO significant pneumonia on CXR. Sedation with ativan adequate 7) Social: Ethics Committee meeting today, Prognosis poor. (b)(6)

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | CONTAINER

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SP | REGISTER NO. | WARD

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

CHRONOLOGICAL RECORD OF MEDICAL CARE — Medical Record — STANDARD FORM 600 (REV. 2-97) — Prescribed by GSA/ICMR — FPMR 101-11.4 — EFRI 201.5.202-1

Exhibit 2

5460-00-634-4178 AUTHORIZED FOR LOCAL REPRODUCTION

DICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

7 Jul 05

Medicine

Remains critically ill. Sedated, intubated & mechanically ventilated

No signs of improvement

Exam Tm 101°, HR 140, BP 88/50, CVP 10 I/O (+) 1500cc

Neck: Supple

Chest: Course BS (B)

Heart: Tachy, S1 murmur

Abd: Soft, distended, edematous.

Ext: 4+ pitting edema

Drips Ativan 1-2mg/hr
Levophed 45mcg/min
DSLR 50cc/hr

Labs ABG 7.35/22/97/97 129/101/73 (23.6) 356 / 3.4/18/2.7 (25.9)

Imp Septic shock with multiorgan failure. Malaria with hepatic fail

No signs of stabilization

Issues 1) ID: D#5 ceftriaxone, D#3 flagyl. Received one dose Gentamyc

2) CV: Escalating dose of norepinephrine. CVP 11, will hold lasix

3) Renal: Oliguric renal failure, rising Creatinine

4) Heme: HCT stable at 26

5) GI: Continued gastroparesis. Bowel wall edema/Sepsis

6) Pulm: Adequate oxygenation on vent. (B) pleural effusion, no infiltrate

7) Social: Prognosis very poor

(b)(6)

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVI | INTAINEE

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP | REGISTER NO. | WARD

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

Ataiwi, Ahmed Ismail
#166576
ICU Bed 1

CHRONOLOGICAL RECORD OF MEDICAL

Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

9 DEC04 **DETAINEE HEALTH AND MEDICAL RECORD OF SCREENING EXAMINATION**
(SF600 OVERPRINT, VER 1.3, IAW AR 190-8)

ALLERGY : FOOD, MEDICINES, INSECTS, PLANTS - NKDA

GENERAL INFORMATION (CHECK ALL THAT APPLY IN THE DETAINEE HEALTH HISTORY):

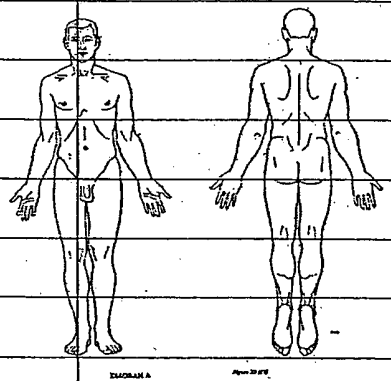
SURGERIES ( )
CONVULSIONS/SEIZURES ( )
HEMOPHILIA ( )
MALARIA ( )
ASTHMA ( )
DIABETES ( )
HIGH BLOOD PRESSURE ( )
CANCER/LEUKEMIA ( )
HEART TROUBLE ( )
KIDNEY DISEASE ( )
VISUAL IMPAIRMENT ( )
HIV/AIDS ( )
STD ( )

NO

IMMUNIZATION GIVEN AT INTAKE? ( )
TB/BLOOD IN SPUTUM/NIGHT SWEATS ( )
LIST ALL MEDICATIONS TAKEN IN THE 30 DAYS **PRIOR** TO TODAY:

TOBACCO USE Y/N NO PP DAY X ___ YRS
ETOH: NO

CASE NO. _____ NAME _____

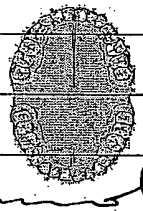


T ___ BP 129/89 PULSE 115 BICEPS CIRC ___
HEIGHT 5'8" WEIGHT 150 BMI 22.9

( ) DETAINEE HAS AN OVERALL (GOOD) ( ) FAIR ( ) POOR STATE OF NUTRITION

VISION: NORMAL GLASSES
HEARING: NORMAL ABNORMAL EXPLAIN

DENTAL



OVERALL APPEARANCE Normal

HEENT Normal HERNIA NP

SKIN /SCARS/BRUISING Normal GENITAL Normal

CARDIOPULMONARY SYSTEM Normal NEUROBEHAVIORAL Normal

MUSCULOSKELETAL Normal DETAILS ON REVERSE SIDE

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	**SSN/ID NO.**	**RELATIONSHIP TO SPONSOR**	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

ISN 166576 CAMP ___
NAME ATAN, AHMED ISMAIL
DOB 1975 AGE 29 SEX M
PROVIDER ___

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

ACLU DDII CID ROIS 38981
000104

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

DETAINEE HEALTH AND MEDICAL RECORD OF SCREENING EXAMINATION
(SF600 OVERPRINT, VER 1.3, IAW AR 190-8)

CONTINUATION:

~~IMMUNIZATION GIVEN TODAY (CIRCLE):~~
(DT) MMR POLIO HEPA HEP B TYPHOID OTHER FLU

LABS (CIRCLE): CBC CHEM 7 UA PPD OTHER_____

CHEST XRAY: NAD ( )

LIMITATIONS
ACTIVITY RESTRICTIONS: NO
~~DIET RESTRICTION:~~ NO
OTHER RESTRICTIONS: NO

TRAVEL (GO/NO GO)
(IF NO-GO ~~LIST~~ REASONS) = GO =

(b)(6)

ISN_____ CAMP_____
NAME_____
DOB_____ AGE_____ SEX_____
PROVIDER_____

STANDARD FORM 600 (REV. 6-97) BACK

0073-05-CID579-40022

MASTER PROBLEM LIST

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

MAJOR PROBLEMS

PROBLEM NUMBER	DATE ONSET	DATE ENTERED	PROBLEM	DATE RESOLVED
1.		01/05	Ø	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

TEMPORARY (MINOR) PROBLEMS

PROBLEM LETTER	PROBLEM	DATES OF OCCURRENCES					
A.							
B.							
C.							
D.							
E.							
F.							
G.							
H.							

PATIENT'S IDENTIFICATION (Use mechanical imprint if available; for typed or written entries give: Name, SSN, Unit, Sex, Birthdate, and Duty Phone)

ATAWI AHMED ISMAIL
166576
DOB
FGN
LI-D

SUMMARY OF PROBLEMS, ALLERGIES, MEDICATIONS, SURGERIES AND TRAUMAS:

A: NKDA
MEDS: Ø

NOTE: DO NOT DISCARD FROM CHART

DA FORM 5571, OCT 86

000106

USAPA V2.0

Exhibit 2

ALLERGIES

MEDICATION	REACTION	MEDICATION	REACTION

CONTINUING MEDICATIONS

PROBLEM NUMBER	DATE STARTED	MEDICATION	SIG	DATE STOPPED

SURGICAL OR TRAUMA HISTORY

OPERATION OR TRAUMA	YEAR	OPERATION OR TRAUMA	YEAR

AUTHORIZED FOR LOCAL REPRODUCTI

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 July	NUTRITION RISK SCREENING
	S/O: ACTIVE DUTY CONTRACTOR (DETAINEE) CIVILIAN ING
	WARD: 1CW BED NUMBER: 12 DX: Anemia, Spleenome Malaria
	AGE: 30 GENDER: (M) F HT: 70" WT: 150 BMI: 21
	DIET: High Protein, ensure & meals
	TOLERATING DIET: no milk products
	A/P:
	NUTRITION RISK:
	Patient determined to be at low risk; will re-screen in one week.
	Patient determined to be at nutrition risk secondary to:
	Further intervention by RD within 48 hours.
	RD recommended
	(b)(6)
	NCD, 344th Combat Support Hospital

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
Camp Buca			
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.
166576 Hawi, Ahmed		

CHRONOLOGICAL RECORD OF MEDICAL CAR
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.0

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July 05	Pt does not tolerate ensure, complain makes him vommit. Wt: 148, BMI: 21, ∅ other changes

☑ Nursing Assessment Reviewed ☑ Vitals Reviewed

PHYSICAL EXAM

General Appearance
- X no acute distress
- __ alert
- __ mild / moderate / severe distress
- __ anxious / lethargic
- __ IV

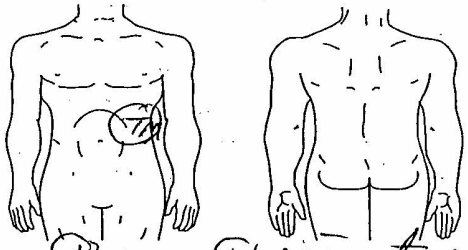
EENT
- ✓ eyes nml inspection
- X ENT inspection nml
- X pharynx nml
- __ scleral icterus / pale conjunctivae
- __ purulent nasal drainage
- __ pharyngeal erythema / exudate
- furred tongue
- __ thyromegaly

NECK
- X nml inspection
- X thyroid nml
- __ lymphadenopathy (R / L)

RESPIRATORY
- X no resp. distress
- X breath sounds nml
- __ chest non-tender
- __ see diagram
- __ wheezing
- __ rales
- __ rhonchi

CVS
- __ regular rate, rhythm
- __ no murmur
- __ no gallop
- __ irregularly irregular rhythm
- __ extrasystoles (occasional / frequent)
- ~~tachycardia~~ / bradycardia
- __ PMI displaced laterally
- __ JVD present
- __ murmur grade ___/6 sys / dias
- gallop (S3 / S4)
- __ friction rub
- __ decreased pulse(s)
  - R carotd___ fem___ dors ped___
  - L carotd___ fem___ dors ped___

T=tenderness
R=rebound
m=mild
mod=moderate
sv=severe
Example- Tsv indicates severe tenderness.



ABDOMEN
- __ non-tender
- __ no organomegaly
- __ nml bowel sounds
- tenderness
- __ guarding / rebound
- __ abnormal bowel sounds
- increased / decreased / absent
- __ hepatomegaly / splenomegaly / mass

RECTAL
- __ non-tender
- __ heme neg stool
- __ black / bloody / heme pos. stool
- __ tenderness / mass / nodule

BACK
- X nml inspection
- __ CVA tenderness (R / L)

SKIN
- __ color nml, no rash
- __ warm, dry
- __ cyanosis / diaphoresis / pallor
- __ skin rash
- cool skin

EXTREMITIES
- __ non-tender
- __ full ROM
- __ no pedal edema
- X pedal edema
- __ calf tenderness

NEURO / PSYCH
- X oriented x3
- X mood / affect nml
- X CN's nml (2-12)
- X no motor / sensory deficit
- __ disoriented to person / place / time
- __ depressed affect
- __ facial droop / EOM palsy / anisocoria
- __ weakness / sensory loss

LABS, EKG & XRAYS:

we attached

CBC		Chemistries			UA	
normal	except	normal	except	CK	normal	except
WBC		Na		CKMB	WBC	
Hgb		K		Troponin	RBC's	
Hct		Cl			bacteria	
Platelets		CO2			dip:	
segs		BUN		PT		
bands		Gluc		PTT		
lymphs		Creat				
monos		Ca		Amylase		
eos				Lipase		

EKG MONITOR STRIP __NSR __Rate

EKG __NML Interpreted ☐ by me ☐ by
☐ Reviewed by me Rate
__NSR __nml intervals __nml axis __nml QRS __nml ST/T
not / changed from:

CXR Interpreted ☐ by me ☐ by
☐ Reviewed by me ☐ Discsd w/ radiologist
__nml/NAD __no infiltrates __nml heart size __nml mediastinum
not / changed from:

PROGRESS:

Time_____ unchanged improved re-examined

__Disc with ☐ Dr._____ ☐ PA / NP_____
will see patient in: office / ED / hospital in _____days
☐ Personally performed physician focused exam

__Counseled patient / family regarding: lab results diagnosis need for follow-up
__Rx given __Admit orders written
__Prior records ordered
__CRIT CARE- 30-74 min 75-104 min _____ min
__Additional history from: family caretaker paramedics

CLINICAL IMPRESSION:

Splenomegaly, Anemia / Fat

DISPOSITION- ☐ home ☐ admitted ☐
CONDITION- ☐ unchanged ☐ improved

(b)(6)

Signature below indicates EMC excluded, stabilized for

ACLU DDII CID R

24 Security Hospital, Camp Bucca, Iraq

EMERGENCY PHYSICIAN RECORD
General Adult (5)

Patient Name:

TIME SEEN: 0130 ROOM: Bucca ED EMS Arrival

HISTORIAN: patient spouse paramedics

HX / EXAM LIMITED BY:

HPI

chief complaint: (1) UQ Pain, Fatigue (2) foot edema

started:

time course:	severity:	modifying factors:
still present	mild	none
better	moderate	
gone now	severe	
worse		

context:

quality:

location:

pt presenting to ER

Similar symptoms previously

Recently seen / treated by doctor

T3103

ROS

CONST
fever (+/-) subjective / to 98.6 °F
chills (+/-)

ENT
sore throat
nasal drainage / congestion

CVS / PULMONARY
cough
sputum
trouble breathing
chest pain

GI
abdominal pain (+) LUQ
nausea / vomiting (+)
diarrhea
black / bloody stools

URINARY
problems urinating
frequent urination

FEMALE GENITAL
abnormal bleeding / discharge
LMP
postmenopausal / hysterectomy

SKIN / MS
skin rash
back pain
leg pain
foot swelling

NEURO / EYES
headache
blackout
lost feeling / power
in arm leg face R / L
difficulty walking
difficulty with speech
double vision
confusion

☐ all systems neg. except as marked

PAST HX negative

neurological problems
CVA seizure disorder

cardiac disease
heart attack (MI) angina
heart failure

high blood pressure

lung disease
asthma emphysema

diabetes
insulin-dependent diet-controlle
oral hypoglycemic

high cholesterol

other problems previous abd pn problem

Medications none see nurses note
ASA NSAID acetaminophen

Allergies NKDA
see nurses note

SOCIAL HX smoker (+) drugs
alcohol (occasional / frequent / recent)

FAMILY HX none reported

20 Abdomen / Male 166574

TRIAGE

Date 3 July 05 TIME 0115 emergent (urgent) non-urgent

NAME: ATAWI, AHMED, ISMAIL
D.O.B 1975 AGE: 30
HISTORIAN: X patient __paramedics __family
ARRIVAL MODE: __car __EMS __police WALKED
PCP: __none
IMMUNIZATIONS: current / ^not current / referral

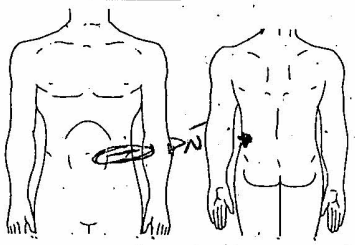
TREATMENT PTA __see EMS report __IV __O_2
Medications:
Interventions:
☐ none

CHIEF COMPLAINT ABDOMINAL PN w/ Lower EXTREMITY INFLAMMATION
started ____ hrs / days ago

__urinary problems	__blood in vomit
X nausea / vomiting x	__blood in stool
__diarrhea	__penile discharge
__fever / chills	__last BM
__back pain	__chemical exposure

quality:
"pain"
aching
dull
burning
cramping
(sharp)
stabbing
fullness

location:



__migration (show migration: ——→)

PAIN LEVEL current: 7 / 10 maximum: 10 / 10

VITALS time: 0103
BP 109 / 68 P 105 RR ____ temp 98.8 TM O R Ax
Height ____ Weight ____ kg
O_2 Sat% 98 RA / O_2 ____ GCS ____

ALLERGIES X NKDA / PCN / ASA / sulfa / latex

MEDS X none __see med list __OTC __vitamins
__herbal preparations

PAST HX X negative
__kidney stone / heart disease / HTN / diabetes *insulin*
__family history of heart disease
__past surgeries *none*
__sexually active
__smoker / drugs / alcohol
__^TB exposure / symptoms
__^has been physically hurt or threatened by someone close

RN Signature (b)(6)

(b)(6) Camp Bucca

EMERGENCY NURSING RECORD

TIME TO ROOM:
INITIAL ASSESSMENT TIME: 0120 ROOM ETR.

GENERAL APPEARANCE

__no acute distress	__mild / (moderate) / severe distress
(alert)	__anxious / decreased LOC

FUNCTIONAL / NUTRITIONAL ASSESSMENT

(appears well nourished	__^obese / malnourished
__independent ADL	__^assisted / total care

RESPIRATORY

(no resp distress	__mild / moderate / severe distress
(nml breath sounds	__wheezing / crackles / stridor
	__decreased breath sounds
	__retractions / accessory muscle use

CVS

__regular rate	X tachycardia / bradycardia / irrg rhythm
X pulses strong	__pulse deficit
X skin warm & dry	__cool / diaphoretic
X nml cap refill	__pale / cyanotic
	__cap refill greater than 2 seconds

ABDOMEN

__nml inspection	X tenderness / guarding / rebound
__non-tender	__distention
X bowel sounds present	__bowel sounds *hypoactive / hyperactive*
__stool heme neg.	__stool heme pos.

GU

X no discharge	__penile discharge
X nml scrotal exam	__scrotal swelling / redness
	__hesitancy / urgency

NEURO

X oriented x3	__disoriented to *person / place / time*
X moves all extremities	__confused
	__weakness / sensory loss

ADDITIONAL FINDINGS

① Pt ambulated TO TIF WITH ABDominal & Lower EXTREMITY INFLAMMATION
② L & R (+) PiT EDEMA IS PRESENT ↑ SWELLING ABD INSPECTION with mild guarding and local PN LATERAL MID SECTION OF (L) SIDE. PN TRAVELS TO MID AXILLARY PT.
③ Drew Bloods (CHEM 12) (Hemo)
④ Pt IS ALERT AND Cooperative!

Nurse Signature ____

^ protocol available

Exhibit 2

CTIONS

ME INIT

O ____ L via

pulse oximeter

hemacult pos / neg

cardiac monitor

Accu-Chek

__bed low position __side rails up x1 x2

__call light in reach __head of bed elevated

__ready for Dr eval. / notified doctor

restraints *see documentation*

/ RECORD

ime	Solution	Site	Ga	Rate	Amt in	Dc'd	INIT

MEDICATIONS

ime	Medication	Dose	Rte	Site	INIT
	Response:				
	Response:				
	Response:				
	Response:				

PROCEDURES

Time		INIT
	Foley fr. mL return	
	straight cath fr. mL return	
	male perineal exam assisted / witnessed by:	
	culture / wet prep	
	NG fr. mL return	
	__to suction *low / intermittent* __placement confirm.	
	Lavage mL fr. *NG / OG*	
	return: *to clear other*	
	sonogram *testicle / scrotal / full abd*	
	cyst I&D performed by:	
	Iodoform gauze	
	urine dip *blood neg trace pos other*	
2115	lab drawn / sent @ 0305	(b)(6)
	results back	
	awaiting physician review	
	to Xray *w monitor / nurse / O_2 / tech*	

VITAL SIGNS

Time	BP	P	RR	T	O_2sat	Rhythm	INIT

N REASSESSMENT

ime	Description	Level	INIT
		/10	
		/10	
		/10	
		10	

ADDITIONAL NOTES

__IV / saline lock discontinued: Time_____ Initials_____

INTAKE	OUTPUT
IV:	Urine:
PO:	Emesis:
Other:	Blood-Approx:
Total:	**Total:**

PROPERTY TO:

__patient __family __security __safe __see patient belongings list

DISPOSITION

__discharged *home police nursing home ME funeral home*

__verbal / written instructions / Rx given to: *patient* _____

__verbalized understanding

__^learning barriers addressed_____

__accompanied by / driver:_____

__pain level at discharge ____ / 10

✓ __admitted / transferred to TCW

__report to (b)(6) time 0345

__transfer documentation completed

__notified family / police / ME _____

__left AMA / LWBS *signed AMA sheet refused* _____

__physician notified of:_____

CONDITION

X unchanged __improved __stable __other_____

Depart Time_____ Mode: *walk W/C stretcher ambulance*

Discharge Nurse Signature (b)(6)

☐ Continuation Sheet

SIGNATURE	INITIAL
(b)(6)	

^ protocol available

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
7 Jul 05	Surg Consult
0912	CC: abd pain
	HPI: Pt c intermit low gr temp; bowels working; occ N;
	hx prev dx jaund. prev pain & swell 2mo ago
	∅ prev malaria that he knows of. ⊕N occ
	PMH: ∅
	PSH: ∅
	SH: ∅ ETOH drugs
	FH: NC
	ROS: Gen: ∅ F/C CV: ∅ ENDO: ∅DM ψ: ∅
	Heme: ∅ bloodi stool, ∅ hx liver/kidney: hx jaund musc/skel: swell (B) ankles
	PE: Gen: in NAD
	CV: Reg & tachy abd: soft sl dist enlarg liver
	pulm: CTA (B)
	neck: ∅ mass ext: 2+ BLE edema MAE
	ent: ∅ erythema ∅ mass neuro: A&O x3 MAE
	LAB: alb <1 TP 4.1 alk 409 ast 28 alt 13 Tbili 0.5 124 / 4.2 | 98 / 28 | 11 / <100 Ca 7.7 phos 4.2 12.2 > 9.8 / 27.9 < 568
	Xray: ∅
	A/P: likely liver dysfunction c anemia and BLE edema
	Cont monit. ✓ INR, CXR Abd xray. ? Ca vs malaria vs viral
	hepatitis cont Diet & fluid restrict

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME LAST | FIRST | MI | (b)(6)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY: TASK FORCE MED 115, BUCCA | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name—last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

166 576

(12) ATAWI, AHMED ISMAIL

DOB 1975

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES

(b)(6)

MEDICAL RECORD 166576 PROGRESS NOTES

DATE	NOTES
7/4/05 0330	Re-examined pt at this time alert oriented x 3 V/S afebrile NSR - Skin pale warm to touch. No abdominal distention noted. Placed in bed c bedroom privileges. Regular diet. (b)(6)
4 July 05 0800	S- Anemia
	Abdominal pain
	O - Lung CTA
	abd soft, non distended
	LUQ abd tender
	Palpable mass — Splenomegaly; tender over spleen
	Ext. +2 Pitting edema
	Ambulatory. No purpura observed
	V.S. 112/76
	T 97.2 Lab 12,200 W
	R 18 8.8 Hb
	P 105 28 Hct
	MCV, MCH, MCHC ↓
	A Anemia / Splenomegaly
	P Splenomegaly w/up Platelets 568
	UA albumin < 1g
	↓ Na ↓ albumin Ca 7.7
	Na K 128 / 4.2 glucose 100
	98 Cl Renal function ✓

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST, FIRST, MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY: TASK FORCE MED 115, BUCCA | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

166576
Atawi Ahmed

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES

(b)(6)

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
06 July 05	Nutrition Assessment: 30 y.o. ♂ c̄ LE pitting edema
	abd pain, splenomegaly, ↓ alb of <1.0, microcytic
	hypochromic anemia c̄ ↓ Hgb ↓ Hct, ↓ MCV, ↓ MCH.
	Test for Fe, TIBC, retic cnt Hep status pending.
	Referred by RN 2/2 wants more protein foods –
	Ht 79 in (2 Ho) wt 150 # BMI 21 (? alb c̄ edema)
	Labs Na+ 128 ↓, Cl- 98 borderline ↓ er NL, alb <1.0, T Pro 4.6
	BUN 11 NL, creat 1.1 BUN/creat ratio 10., CA 7.74, corrected
	for ↓ alb (10.1) – would ✓ ionized CA++ if possible.
	Meds: noted
	Diet: Regular c̄ 2L fluid restriction intake poor;
	dislikes milk
	Assessment: Needs based current wt 68kg = ~1800–~~1900~~ 2000 cal/d
	(27-30 cal/kg) ~90–100 gm pro/d (1.3–1.5 gm/kg) will need reassess
	once Dx for px ascertained.
	Recommend: 1) Dbl portions of soup/meat sauce q lunch
	2) Ensure Plus q meal @ 170ml fld each can @ 510ml fld
	for 3 cans/d c̄ 39 gm protein 1080 additional calories
	Pt is @ ↑ nutrition risk F/U ≤ 5 days.
	(b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY: TASK FORCE MED 115, BUCCA | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

166576 Bed 12
Atawi, Ahmed Ismail

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V1

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(b)(6)

STANDARD FORM 509 (REV. 5/199

US.

DATE	NOTES
06 JULY 05	Second Review
2100	30y/o ♂ c recent onset LUQ discomfort, swelling, peripheral edema and low grade temps. Complaints 1st noticed ~ 2 wks ago. No recent of significant medical hx otherwise. Patient triaged in ER c Surg. c/s provided. Subsequent assessment revealed splenomegaly, microcytic anemia, hepatomegaly and bilateral lower ext edema @ ankles. Concerned hypoalbuminemia also uncovered.
	Constellation of signs and symptoms raised suspicion for viral vs parasitic vs malignant source of illness.
	Lab report this evening confirmed suspicion of malaria. Differentiation of malaria type not available c current lab assets.
	Will review antimicrobial guidelines (STANFORD / CDC) for treatment options endemic to this region and start tx as appropriate. (b)(6)
	Per CDC guidelines, MIDDLE-EAST is a chloroquine sensitive area. (b)(6)
0730 06	Pt c/o pain / N/V on ♀ MN. Tx c pain med + anti-emetic s/o resolved. No c/o pain, nausea in AM. VSS.
	Continue current regimen. Adjust tx per lab.

Atawi Ahmed
166576
BED 12

(b)(6)

STANDARD FORM 600 (REV. 5/199 US

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD | PROGRESS NOTES

DATE | NOTES

07 Jul 05 MED NOTE

D/W DETAINEE his malaria + Pulm and antiseptal cause of resolution. Explained reasons of HSM & subsequent periph edema.

Will Follow daily

(b)(6)

08 Jul 05 HO H4

10:00 S: noticing leg swelling ↑, also vomited once yesterday. eating ok & ambulating w difficulty

O: V/S Pertinent for Fever, low BP

CHEST: S1S2, LCTAB

ABD: HSM unchanged, soft ⊕BS

EXT: +3 pitting pretibial & pedal edema bilaterally

(b)(6)

Imp: 30yo AAE advanced stage malaria c/b assoc hepatosplenomegaly, malnutrition, liver dysfunction resulting in hypoalbuminemia and subsequent third-spacing of fluid → hyponatremia.

Plan

Continue malaria tx.

Add diuretic as tolerated by BP & ↓ FREE WATER to < 1L/day

(b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME | LAST | FIRST

PART./SERVICE | HOSPITAL OR MEDICAL FACILITY: TASK FORCE MED-115-BUCCA

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO.

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(
USAPA V.1

DVIF

EDICAL RECORD — PROGRESS NOTES

DATE	NOTES

09 July 05 HD # 5 – MEDICINE NOTE

10:15 S: Tolerating ↑ protein diet, but c/o jello/crackers/cheese causes him indigestion/nausea. Emesis x1 yesterday afternoon. ↓ swelling in his legs this morning. Ambulating & dizziness despite low BP and relative tachycardia

O: V/S 88/52 HR 112 RR 18 T 97.9 Pox 98%.

General: A&Ox4 NAD; speaks clearly thru interpreter

CHEST: S1/S2 LCTAB; HR>LUD

ABD: soft, (+)BSM, (+)BS

EXT: 1+ (+)3 pitting edema of both lower legs

LABS: 123 / 96 / 10 / 78 Phos 3.6 Alb 2.1.0
4.3 27 0.6 Ca++ 7.3

Impression

30 y/o man c melena and subsequent HSM/Microcytic anemia/hypoalbumine and resulting hyponatremia from 3rd spacing. Possible SIADH 2° to infect

Plan

Start standing order for antiemetic, Add Start to diet & M

Adjust diet to ↑ tolerance

Continue plan otherwise as stated yesterday

(b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME (LAST / FIRST / MI)	SPONSOR'S ID NUMBER (SSN or Other)

PART:/SERVICE	HOSPITAL OR MEDICAL FACILITY
	TASK FORCE MED 115, BUCCA

(b)(6)

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name, last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

Hawi Ahmed
166576

COMPOUND #

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 July 05	S. Malaria / Spleen megaly / Hyponatremia Hypoalb. / Anemia
	O. Lung cm Heart RRR
1500	++ Peripheral edema Ascites
	A Malaria / Spleenomegaly (b)(6)
	P Reviewed Med Record
	NaCl
	Vit. Protein
	Chloroquine (b)(6)
	Lab July 9
	albumin < 1 g/dl 128 / 97 / 4.2
	Bun 10 mg/dl
	6.7 mg/dl
	Lat July 4 anisocytosis microcytic
	hypochromic
	Ferritin (b)(6) ? — OK Malaria smear
	+ Schistocytes
09 July	Nutrition F/U: Noted 90 foods that cause nausea.
	Pt does not receive cheese, jello, crackers, or milk.
	Must be encouraged to drink Ensure Plus. Noted dx & labs
	ō ↓ alb, Na+ 2/2 liver involvement ō malaria.
	Will attempt to obtain 2 eggs q AM instead of one ō ?
	dfc, Receiving MV/min — please give ō food or Ensure to ↓
	GI distress. Unfortunately prealb not option, 2/2 send out &
	date ∅ available in time to intervene. F/U biweekly (b)(6)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — PROGRESS NOTES

DATE	NOTES
10 Jul 05	No c/o. Ambulating to BR s̄ symptoms
	T 98³ P 104 R 20 BP 89/51 Pulse Ox 99% (b)(6)
	Heart Regular Lungs Clear
	Abd Liver [illegible] 3 fingerbreadths - palpable spleen
	Extr - 2-3+ pitting edema
	Lab (9 Jul 05) Na⁺ 128 Alb remains <1, Ca⁺ 6.7 (corrected 9
	(A/P) Malaria - sobacute - Chloroquin
	Hypoalbuminemia - ↑ Protein in diet
	Hyponatremia - fluid restrict, low dose diuretics (watch BP)
	Anemia - Iron replacement
	DAVIS, COL
11 JUL 05	Had a rough afternoon yesterday → ↑ pain meds. - feeling okay this morning. Still complains about the food - have requested food to his liking - pt encouraged to eat ↑ protein
	T 97 P 108 R 28 BP 81/52 O2 sat 100% on RA
	Slightly anxious but NAD, Heart RRR ⊝M, Lungs CTA
	Abd soft, NT, H-S megaly unchanged, ⊕ BS
	(A) Malaria / H-S megaly / Anemia / Hypoalbuminemia
	(P) Cont present Rx, follow labs
	(Hb 8.3 stable, Na⁺ 130, ⊕ paresthesia)
	DAVIS, COL MC

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST / FIRST / MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY: TASK FORCE MED 115 - BUCCA | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

166576
Hamdi Ahmad
11 Sep 02

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/..)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)
USAPA V

ACLU DDII CID ROIS 39001

DATE	NOTES
11 July 05	Nutrition F/U: Pt c/o px c̄ all dairy products - pt not receiving - Diet protein ↑ to 1 egg q AM (ensure diet 3 wk), dbl portions of soup/pulse stew q lunch, Ensure Plus TID. ≈ additional 36 gm prot/day if consumed.
	Noted addition of FeSO4 325 mg BID. Would provide c̄ vit C ~250 mg BID to enhance Iron absorption & metabolic utilization. Would give both c̄ meals ↓ GI distress.
	alb remains < 1.0 c̄ ↓ Na ↓ Cl = likely ↓ compounded to fluid retention 2/2 interstitial/extravascular accumulation c̄ ↓↓ albu level.
	Ca 7.0 ∠ corrected for ↓ alb ≈ 9.48] ionized CA++ would be ideal to assess but not realistic c̄ length of time to receive results c̄ send out process.
	PO4 ↑ CA++ ↓ Pt does not consume dairy may need CA++ supplementation.
	[Recommend:] 1) Give FeSO4 c̄ vit C ~250 mg BID give both c̄ meals to ↓ GI distress.
	2) Consider CA++ supplementation - pt refuses dairy products.
	3) Encourage intake of Egg, Ensure, dbl portions of meat/pulses q lunch. Needs protein & sufficient calories for protein sparing for anabolism
	(b)(6)
12 Jul 05	Stable. Still c/o nausea - Above recommendations noted
	(P) Trial of Reglan (b)(6)

0073-05-CID579-40022

DATE	NOTES
4 July 05	Nurses Notes
	Received detainee in ASU in no acute distress. Had hygiene care done and allowed breakfast. Blood drawn and sent for CBC and Type and cross match. Hgb 15.4, HCT 44.1 To be transfused with 2 unit PRBC when blood is available.
12N.	Detainee C/O nausea & abdominal pain. Informed Tordol 60 mg IM given as ordered will monitor for effect. (b)(6)
12:15	IV access started in (Rt) AC with 20g for blood transfusion. Tylenol 650 mg & Benadryl 25 mg PO given prior blood transfusion. (b)(6)
12:35	1st unit PRBC started 0 positive # (b)(6) ISN # 166576. V/S taken & recorded. No immediate transfusion reaction noted. 2nd unit to follow. (b)(6)
1441.	1st unit of PRBC completely absorbed, no transfusion reaction noted. 2nd unit started 0 pos # (b)(6) V/S done & recorded no immediate transfusion reaction noted. BP 86/52
17:02	Blood transfusion completed no transfusion reaction noted. (b)(6)

STANDARD FORM 509 (REV. 5/1993)

USAPA

Exhibit 2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
13 Jul 05	Still c/o nausea, anorexia - on MVI, Vit C, Protein shakes
	Exam unchanged. Initially though Wt Reglan helped a little.
	Continues on Chloroquine for malaria and FeSO4 for anemia
	Albumin remains < 1.0. BP ~ 80-90 systolic
	(A) Malaria
	Pt's megaly c hypoproteinemia and anemia
	(P) Continue care
	(b)(6)
13 Jul 05	Pt cont c GI distress w/ & without food/fluids.
	Continues to complain of milk (not receiving any milk or milk products for nutrition care). Reported tolerances to Ensure varies. Tried Entrée & Pro clear but pt did not like it. Tried Promod protein powder in juice & fruit. Pt tolerated/accepted. Double portions soup offered @ lunch. Will try to 2@ bkfst + (OK'd by Kinema). Offer fruit Promod shakes, Encourage Ensure Plus. Pt may need PM tube feeding (duodenal placed) if intake does not improve & antinausea/prokinetic. Recommend Dr Chang Vit C to 500mg BID give c FeSO4 c food to enhance absorption/↓ GI distress
	(b)(6)
	Addendum Will attempt to bypass Tamimi/dtor system to obtain more food

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other) thanks

(b)(6)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY: TASK FORCE MED 115, BUCCA | REGISTER

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1?)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

ID 165276 Atawi, Ahmed

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
15 Jul 05	Feeling much better today after transfusion of PRBC's – no untoward reactions
	Ate breakfast, less nauseated. AF VSS – Lungs clear Heart RRR
	Abd – less distended – ⊕ H-S megaly ⊕ BS, nontender
	H/H – 7.5/ 24 pre-transfusion post-transfusion CBC pending
	(A) Malaria
	Splenomegaly – anemia
	Hepatomegaly – hypoalbuminemia
	(P) Cont' fluid restriction – ↑↑ protein diet
	Monitor H/H Fe replacement Doxycycline (b)(6)
15 July	Nutrition FU: Ate better today, feeling & looking stronger.
	Received PRBC 14 July. Receiving FeSO4 & Vit C BID (PRBC
	also contains Fe). Still ↓↓↓ alb, ↓ but improving Na level 13[illegible]
	Cl – 100.
	Receiving 2 eggs bkfst, meat/pulse stew lunch & supper,
	Promod/Juice Shakes BID PM & HS snack.
	Refuses milk, cheese (all dairy) & refuses Ensure.
	Plan: Continue ↑ protein diet, ↑ protein fruit shake BID
	& encouragement to eat. FU (b)(6)
16 Jul 05	Feels hungry today – Continue double portions, dietary supplements
	On Doxycycline – WBC ↓'ed to 13.4 (b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY: TASK FORCE MED 115, BUCCA | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

166 576
ATAWI Ahmed Ismail

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1[illegible])
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

ACLU DDII CID ROIS 39005
000128

Exhibit 2

DATE	NOTES
17 Jun 05	NO vomiting today. Remains hungry - complaining about food. Have explained dietary limitations - pt receiving double portions but refusing much of the food (A) Malaria + anaemia and hypoproteinaemia (P) Cont: dietary supplementation Consider return to compound (?)
19 Jun 05	Internal medicine No. Complaints overnight. Oral intake much better Tmax 99.5 Vitals: BP 100/60, HR 100 Chest: clear Heart: Tachy, reg rhythm Abd: Soft Ext: 2+ edema Labs: Alb < 1.0, Creat 1.0, Bun 7, Na+ 127 Hct 27.6/44.1
	Imp: Advanced stage Malaria complicated by hepatosplenomegaly hypoalbuminemia and hyponatremia due to volume retention. Plan: D1D: Received chloroquine, continues course of doxycycline If fever or hemolysis recurs, will have to consider hepatic reservoirs or CQ resistance. 2) Lytes: Continue fluid restriction, Advance protein intake Repeat labs on Thursday.

(b)(6)

(b)(6)

STANDARD FORM 509

MEDICAL RECORD - PATIENT REASSESSMENT

For use of this form see MEDCOM Circular 40-5

DIRECTIONS: A check (✓) in the small box indicates stated description reflects actual physical findings. An asterisk (*) in the box indicates that a variance exists. A brief explanation of any abnormal findings is required.

DATE:	TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL. Alert and oriented to time, place, self, and situation. Responds appropriately. Communication is adequate to express needs. Pupils equal bilaterally and reactive to light. Upper/lower extremeties strong and bilaterally equal.	✓ (b)(6)		
2. CARDIOVASCULAR. Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness or chest discomfort.	✓ (b)(6)		
3. PULMONARY. Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. Lungs clear to auscultation, all lobes. Chest movement is symmetrical.	✓ (b)(6)		
4. G.I. Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea, or rectal bleeding. No change in appetite.	✓ (b)(6)		
5. G.U./REPRODUCTIVE. Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual vaginal/ penile/breast discharge.	✓ (b)(6)		
6. MUSCULOSKELETAL. Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal ROM without pain. No joint swelling/ tenderness, weakness, or paresthesia.	✓ (b)(6)		
7. SKIN. Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist and intact.	✓ (b)(6)		
8. PAIN.	☐ Denies pain/discomfort.	☐ Denies pain/discomfort.	☐ Denies pain/discomfor
Note: If patient complains of pain/discomfort, document the intensity (0-10 item scale), location, and other descriptive information in item			
9. PSYCHOSOCIAL. Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate. Interacts appropriately with others.	✓ (b)(6)		
10. SLEEP. Patient expresses he/she slept well and feels rested.	✓ (b)(6)		

PATIENT'S IDENTIFICATION *(For typed or written entries note: Name - last, first, middle intial; grade; DOB; hospital or medical facility)*

166576 #2

NOTE: Additional assessment data regarding IV site pain, dressings, etc., is contained on page 2 of this fo

Exhibit 2

11. IV SITE. (Condition Legend: P - Puffy I - Infiltrated In - Indurated R - Reddened OK - No swelling/redness * - Central line)

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
IV patency check q hr:	IV patency check q hr:	IV patency check q hr:
SITE 1 SITE 2	SITE 1 SITE 2	SITE 1 SITE
Insertion date	Insertion date	Insertion date
Catheter size	Catheter size	Catheter size
Location	Location	Location
Condition	Condition	Condition
Site care provided	Site care provided	Site care provided
Tubing changed	Tubing changed	Tubing changed
IV site changed	IV site changed	IV site changed
Comment:	Comment:	Comment:

12. PAIN. For location of pain, use the anatomical numbering scheme (Figure 1) displayed at the bottom of this page.

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
Location:	Location:	Location:
Intensity (0 - 10 scale):	Intensity (0 - 10 scale):	Intensity (0 - 10 scale):
Description:	Description:	Description:
Increased by:	Increased by:	Increased by:
Relieved by:	Relieved by:	Relieved by:

13. OTHER INTERVENTIONS. Document assessment and care of any drains, wounds, dressings, etc., in the spaces provided below.

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
Intervention:	Intervention:	Intervention:
Findings:	Findings:	Findings:

14. COMMENTS:

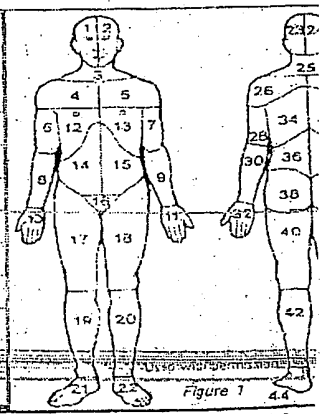


Figure 1

EDICAL RECORD — PROGRESS NOTES — 0073-05-CID579-40022

DATE	NOTES
5 July 05 1430hrs	OOB, for AM care and anal hygiene care & other detainees. Appetite improving tolerated breakfast and lunch well & fluid intake. Socializes very little w other detainees. Slept most of the afternoon c/o no pain. (b)(6)
11 July 05	Detainee A&A verbal, OOB → BR → shower, VSS T2-T3 pitting edema to lower extremities. No acute changes Status. Skin assessment done, no breaks noted. Will monitor. (b)(6) to see lab results. — (b)(6)
23 July 05 0840hrs	Detainee in bed c/o being cold but stated he wanted to go outside for AM care and change his pajamas and come back inside. Detainee went outside and within 30 mins detainee noted to be very lethargic diaphoretic cold, clammy and not responding verbally. Staff on
0910hrs.	Detainee was placed in bed after being lifted from w/c. Detainee cyanotic and pasty and pts peripheral pulses imperceptible. Pro pac placed on Rt forearm B/P 126/86 no pulse recorded. O_2 via NRM started IVF placed in Lt arm with N/Saline code open. Placed on cardiac monitor HR 50 B/P 70/44. O_2 Saturation

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
				166576

PART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT
	TASK FORCE MED 115, BUCCA	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.

WARD NO. ICW

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V1

166576

BED #12

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
			166576

DATE	(Cont) NOTES
23 July 05	~~Atc~~ airway not picking up due to cyanosis. (b)(6)
0910hrs	notified of detainees condition and started Cent
1000hrs	line. Lidocaine given and central line inserted in
	Rt femoral vein. Bladder region distended foley
	was placed - no urine returned. ABG done by
	respiratory therapist (b)(6) and blood drawn
	and sent to lab for CBC, ō diff chemistry LFT Fin
	stick - blood sugar done 339 mg/dl.
1030hrs	Detainee ~~stated~~ airway started to respond and communicate
	verbally B/P 81/50. 12 lead EKG done & read by (b)(6)
	Detainee was transferred to ICU for further
	management care. (b)(6)

STANDARD FORM 509 (REV. 5/1999)
USA

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 0800 HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 4 JuLy'05

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0800	120 cc		
1230	240cc		
1600	800cc		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (A.G. Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

166576
Bed 12

Exhibit 2

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL
1401	0	ZOVCC	

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give Name - last, first, middle, grade, date, hospital or medical facility)*

INTAKE EQUIVALENTS *(Serving levels, cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED.

USAPPC V1

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE: 15 July – 17 Jul

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0800	120		
1000	200		
1200	60		
1600	240	15 July	660
0800	200		
1000	240		
1200	120		
1600	180	16 July	740
0800	240		
1000	120		
1200	240		
1600	120 + 60	17 July	720

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS (N.G. Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL
12:30	PRBC	14:41	250	250
14:41	PRBC		250	250

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

Bed #12

Exhibit 2

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give Name - last, first, middle, grade, date, hospital or medical facility)*

166576 #12

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1

0073-05-CID579-40022

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407;
the proponent agency is the Office of The Surgeon General.

Mo. July Yr. 05

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4 5 6 7 8 9 10 11 12 13 14 15 16 17
4/July 05	(b)(6)	V/S Routine	D	(b)(6)
			18	(b)(6)
4/July 05		Regular Diet	B	(b)(6)
			L	
			D	(b)(6) (b)(6)
4 July		Bathrm Privileges		(b)(6)
6 July 05		Change diet order to recommendations as per nutritionist team Double portions soup meat Sauce at Lunch and	B L D	(b)(6)
6 July 05		Ensure Plus ē Each meal	B	(b)(6)
			L	
			D	
6 July 05	(b)(6)	Continue Fld Restriction at 2L per Day	QD	(b)(6)
8 July 05		Δ Fluid Restriction to 1L per Day	QD	X X X X (b)(6)
14 July		Transfuse 2 units PRBC	1230	(b)(6)
14 July		Premed ē 1/4 Benadryl 650 + Benadryl 25mg PO	1245	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: R/O Splenomegaly, Anemia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:
Atawi Ahmed
166576

#12

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES
D 8 9 10 11 12 13 14 15
E 16 17 18 19 20 21 22 23
N 24 01 02 03 04 05 06 07

DA FORM 4677 EDITION OF 1 DEC 77 MAY BE USED.

ACLU DDII CID ROIS 39015
000138

ACLU-RDI 5494 p.134

Exhibit 2

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PL
(NON MEDICATION)

Order Date	Clerk / Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	(9)(q)	V/S Routine				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Ward L

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMIN.

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6	7	8	9	10	11	12	13	14	15	16	17	18	19
8 July 05	(b)(6)	Chloroquine Phosphate (aralen) P.O 1000mg Salt x1	0800	(b)(6)													
			2330														
		chloroquine															
08 July 05	(b)(6)	Phosphate (aralen) P.O 500mg Salt	0800		(b)(6)												
			2330														
06 July	(b)(6)	chloroquine Phosplate P.O 500mg	0800			(b)(6)											
			2330														
08 July 2005	(b)(6)	Lasix 20mg PO BID	1000	X	X	(b)(6)											
			2200	X	X	(b)(6)											
09 July	(b)(6)	Multivitamins QAM c breakfast PO	1000	X	X	X	(b)(6)										
10 July	(b)(6)	Fesol 325 mg po bid	1000	X	X	X	X	(b)(6)									
			2200	X	X	X	X	(b)(6)									
10 July	(b)(6)	Celace 100mg po bid	1000	X	X	X	X	(b)(6)									
			2200	X	X	X	X	(b)(6)									
11 July 05	(b)(6)	Lasix 20mg po daily	1000					(b)(6)									

Alert See New Order 11 July 2005 (b)(6)

See 13 July New Order (b)(6)

DC 12 July (b)(6)

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: R/O Splenomegaly / Anemia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

Atawi Ahmed

166576

#12

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

000140

Exhibit 2

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. ____ Yr. ____

Verify by Initialing

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
7 July	(b)(6)	Morphine 6mg IV x1	0045	0045	7 July	(b)(6)
07 July		Reglan 10mg IV x1	0045	0045	7 July	
07 July		Benadryl 50mg x1	0045	0045	7 July	

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED			
8 July	(b)(6)	APAP 650mg q4-6 PO prn.	9 July 0415 (b)(6)	10 July 0800		
9 July 2005		Zofran 4mg IVPB BID/PRN for Nausea	10 July 3:00 (b)(6)		D/C 7/12/05	
13 July 2005		Colace 100mg PO PRN				

0-00-634-4176

DICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
1 July 05	S- Hypo volemic
700	Hypo tension
	Hepatic Failure
	No oral intake
	O- Lung CM hyper
	V.S. 92/58 117 3
	79/41 113 38
	81/48 112 57
	Lab. alb <1.0 wbc 14,600
	alp 162 Hb 9.3
	alt 122 Hct 30
	AST 387 mcv
	Tbil 0.5 mch
	BUN 25 MCHC 31
	Creatinine 1.3
	glucose 169
	125
	5.7

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)		REGISTER NO.	WARD

#166576

Atawi, Ahmed Ismail

ICU Bed 1

CHRONOLOGICAL RECORD OF MEDICAL
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/NARA
FIRMR 141 CFR 201-45.303

Exhibit 2

EDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
24 Jul 05	(S) Feeling better - less dyspneic - wants to go back to ICU
	Less chapped lips - hungry (?)
	(O) BP 75/48 Temp 94 Ax P 116 R 24 Pulse ox 100% on O2
	Lungs - RUR crackles - basilar crackles - o/w clear
	Abd - absent bowel sounds, soft not board-like
	Extr - cool, thready pulses In - 2200 Out - urine 70cc NG 300cc
	Labs K+ 5.7 Na 125 Glu 169 (4 amps of D50 in past 24°)
	WBC 14.6 H/H 9.3/30.0 TCO2 17 (up from 11)
	BUN 1.0 Cr 7.3 BUN/Cr 25/1.3
	(A/P) Sepsis/ABF - IVF, Albumin, Rocephin
	Hypoglycemia - D50, monitor Glucose, D5
	Hyponatremia - D to NS from ½ NS
	Hypoalbuminemia/pedal edema
	Oliguria/ARF - high volume fluid replacement
	Lactic acidosis 2° sepsis - consider NaHCO3 if CO2 < 14
	Hyperkalemia - Kayexalate if > 6.0
	Malaria - on Mefloquine and Doxycycline
	Atelectasis - encourage deep breaths, O2 to keep sats ≥ 95%
	Ileus - NG decompression - ✓ KUB
	Pregnant guarded - Command element aware
*	Add: Case discussed c CDC Hagge, CI at Abu and
	c (b)(6) ED @ WRH

(b)(6)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)		REGISTER NO.	WARD

CHRONOLOGICAL RECORD OF MEDICAL
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by SAAMO
FIRMR 141 CFR 201-8.202.1

Exhibit 2

DATE/TIME | SYMPTOMS, DIAGNOSIS, TREATMENT | TREATING ORGANIZATION (Sign each entry)

24 Jul 05 | Urine output 10 cc/hr past 2 hrs.

12:15 | P/w - Add Renal dose Dopamine

(b)(6)

STANDARD FORM 600 (REV. 6-97) B.

40-00-634-4178

DICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

5 Jul 05 — medicine

Developed worsening respiratory distress yesterday afternoon leading to tracheal intubation & mechanical ventilation

Currently sedated, on vent and pressor support

Exam/Data: Afibrile, BP 80/50, HR 130, RR 18

Neck: Supple

Chest: ↓ BS (B) bases

Heart: Tachy, reg rhythm

Abd: Soft distended, edematous. HSM

Ext: 3+ diffuse pitting edema

infusions: Dopamine 10mcg/kg/min; Diprivan 30cc/hr; D5 LR 150cc/hr

Vent: FiO2 80% TV 700, VR 14

CXR: (B) pleural effusion

labs: 9.6 / 247 / 492 | (126)/52 | 93/(17) | 28/1.1 | 107 | AH (127) | AP (185) | Tb 0.6 | Alb KI.0

Imp: Hepatic failure presumed due to chronic malaria, now superimposed sepsis. Critically ill.

Plan: 1) ID: D#2 Ceftriaxone. No cultures available. 10 day course planned. GI is assumed source (bowel edema, ? megacolon). Completed 2 courses of Rx for malaria. Residual parasites on smear

2) CV: Pressor support with dopamine. maintain CVP ≈ 15 IVFs / lasix prn

3) Renal: Oliguric renal failure. lasix prn to keep UOP

4) Heme: HCT stable. Transfuse if HCT falls to ≤21

5) GI/Liver: Supportive care. Consider tube feeds in 48hrs.

6) Pulm: Continue mech. ventilation. Switch to Ativan.

(b)(6)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	INEE
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO S	
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)		REGISTER NO.	WARD ICU

166576

ATAWI, Ahmed Ismael

CHRONOLOGICAL RECORD OF MEDICAL
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/NARA
FIRMR 141 CFR 201-45.505-1

Exhibit 2

STANDARD FORM 600 (REV. 6-97) Prescribed by GSA

540-00-634-4178

DICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

6 Jul 05

Medicine

Remains Critically ill. Sedated, intubated, mechanically ventilated

Exam Tm 100, HR 130s, BP 91/45 CVP 12-14

NECK: Supple

Chest: clear anteriorly

Heart: Tachy, reg rhythm

Abd: distended, edematous, Soft

Ext: 4+ edema

Vent FiO2 35%, Vt 700, VR 14

Infusions norepi 25mcg/min
DSLR 50cc/hr

Labs (233)/25-9 <452 132/5.4/19/35/1.3/89

Imp: GI Sepsis with underlying chronic malaria & hepatic failure.
Remains pressor dependent and mechanically ventilated.

Plan 1) ID: D#1 Ceftriaxone. D#2 flagyl. Increased leukocytosis noted
If this continues, will add additional gm(-) coverage.

2) CV: Continue norepi ≈ 25mcg/min. Stable BP over past 24hrs.

3) Renal: Oliguric renal failure. Add scheduled lasix dose

4) Heme: HCT 26% and stable.

5) GI/Liver: Hepatic failure, gastroparesis with Fd NG? Out put
Not ready for tube feeds. Continue Zantac

6) Pulm: Continues mechanical ventilation. NO significant ~~infiltrate~~
on CXR. Sedation with ativan adequate

7) Social: Ethics Committee meeting today. Prognosis poor.

(b)(6)

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | NEC

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SP | WARD

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) | REGISTER NO.

CHRONOLOGICAL RECORD OF MEDICAL
Medical Record
STANDARD FORM 600 REV. 6-97
Prescribed by GSA/NARA
FIRMR 141 CFR 201-45.101-1

Exhibit 2

26 July 05 Medical Nutrition Therapy. MD notes reviewed - enteral tube feeds cont to be contraindicated. TPN ↓ dose hypocaloric may be contraindicated 2/2 ↑ K+, see TPN solutions given 4/5/6 @ TF with electrolytes. Will follow for plan of care E window: for feeding. FU ≤ 2-3 d.

(b)(6)

DICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)

7 Jul 05

Medicine

Remains Critically ill. Sedated, intubated & mechanically Ventilated

No Signs of improvement

Exam Tm 101°, HR 140, BP 88/50, CVP 10 IIO (+) 1500cc

Neck: Supple

Chest: Course BS (B)

Heart: Tachy, Murmur

Abd: Soft, distended, edematous.

Ext: 4+ Pitting edema.

Drips Afrain 1-2mg/hr
Levophed 45mcg/min
D5LR 50cc/hr

Labs ABG 7.35/22/97/97 129/5.4/101/18/27/73 (23.6)/(25.9)/356

Imp Septic Shock with multiorgan failure. Malaria with hepatic failure
No signs of Stabilization

Issues 1) ID: D#5 ceftriaxone, D#3 flagyl. Received one dose Gentamycin

2) CV: Escalating dose of norepinephrine. CVP 9, will hold lasix

3) Renal: Oliguric renal failure, rising Creatinine

4) Heme: HCT Stable at 26

5) GI: Continued gastroparesis. Bowel wall edema/Sepsis

6) Pulm: Adequate oxygenation on vent (B) Pleural effusion, no infiltrate

7) Social: Prognosis very poor

(b)(6)

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SER

SPONSOR'S NAME | SSN/ID NO. | RELATIONSH

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

Atawi, Ahmed Ismail
#166576

CHRONOLOGICAL RECORD OF MEDICAL
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

ACLU DDI CID ROIS 39028

21 Jul 06

1500 Medicine

1430 Acute bradycardic arrest

HR 135→40, BP indetectable

Given 1 amp Atropine, 1 amp epinephrine

Brisk response with HR increase to >200, BP 170/60

ABG 7.16/33/20?

Inf metabolic acidosis related arrest

Given 1 amp Bicarbonate

↑ VR to 16. Continue bicarb gtt

Prognosis grave

No urine output.

(b)(6)

1530 Medicine

Acute PEA arrest

See codes note

ACLS 15mins including repeated doses of epinephrine and defibrillation x4 for intermittent VF

Also 1amp Calcium Chloride, 1 amp HCO_3

No response

final rhythm pulseless electrical activity HR < 20

Death @ 1529.

(b)(6)

1535 (b)(6) has Contact (b)(6) from CID.

(b)(6)

STANDARD FORM 600 (REV. 6-97) B.

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
NIBP/ ABP		admitted fr			153	54	Refer to vital signs flowsheet									
Pulse				ICU	106	110										
Respirations					35	34										
Temperature					92											
SaO2																
%O2					100	100										
O_2 Delivery					NR	2L NC										
~~CVP~~																
Rhythm					ST	ST										
Pain Scale					0	0										
Pain Med					0	0										
Pt Position					sup	S										

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV NS						500	250	250	1000	~~600~~ 400	150	150 > D/C						900
IVPB Rocephin												200						200
IV D5½NS												150	100	100	100	100	100	550
Albumin x/ext 500												150	100	100	100	100	100	550
PO						60		H20 30	90 NPO		—					30		30
Other																		
TOTAL																		

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output Hour/Total		Foley inserted			0									30cc			40	70
NG output																		300
Emesis																		
Stool																		
Chest tube #1/ #2																		
Jackson Pratt #1/ #2																		
TOTAL																		

ASPECT	TIME/INITIALS	
Bath/Skin Care	1800	(b)(6)
Oral Care		
Foley Care		
Trach Care		
Range of Motion		

Safety	D	E	N
High risk for falls	(Y) N	Y N	(Y) N
Call bell in reach	(Y) N	Y N	(Y) N
Bed position/Locked	(Y) N	Y N	(Y) N
Protective device	Y (N)	Y N	Y (N)
Cardiac Monitor	(Y) N	Y N	(Y) N

Exhibit 2

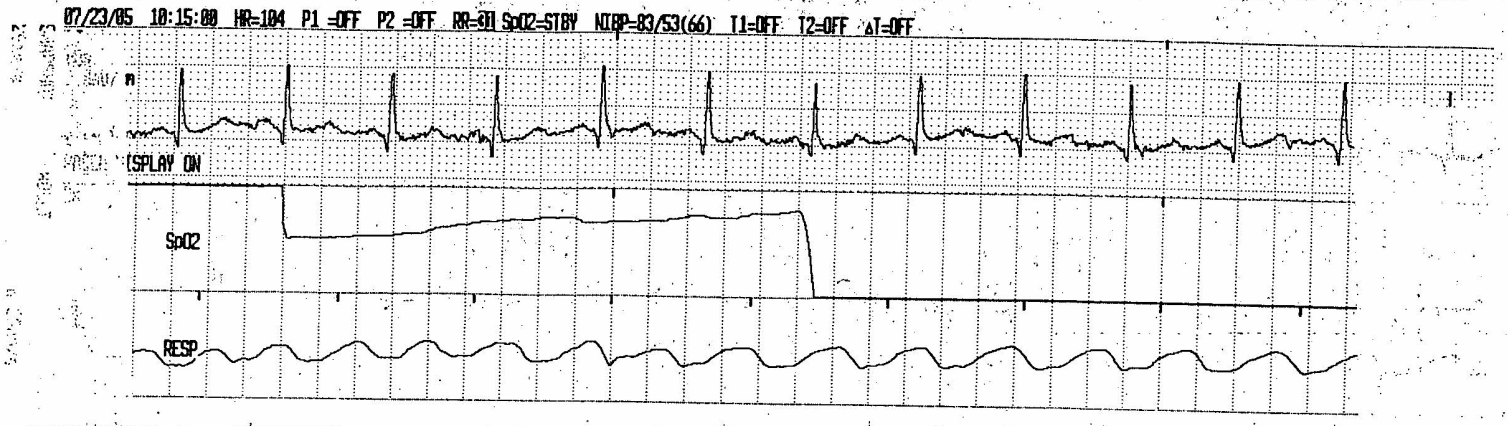
MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

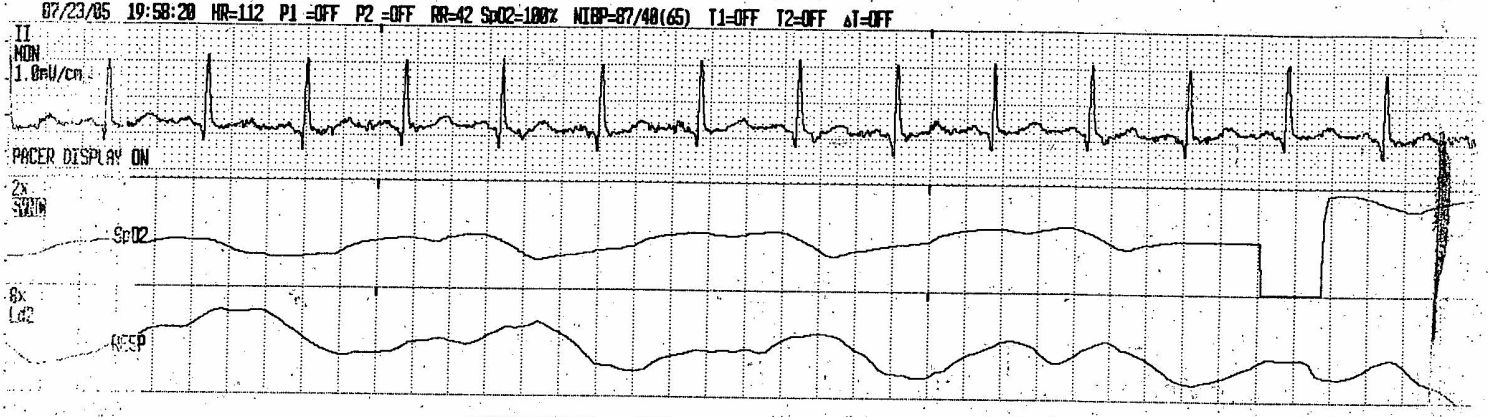
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: **ICU FLOW SHEET**

OTSG APPROVED *(Date)*:

EKG STRIPS





VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
central line (R) groin	23 Jul 05	26 Jul 05	clean, dry, intact	Redressed.	
IOG (L) fA	23 Jul 05	26 Jul 05	clean, dry, intact	Inf. Hrate, DC'D by RN	—

(Continue on reverse)

PREPARED BY *(Signature & Title)*: (b)(6)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 23 Jul 05

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

#166576 ICU 1

Atawi, Ahmed Ismail

- ☐ HISTORY/PHYSICAL
- ☒ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

SYSTEM	DAYS	NIGHTS
NEURO		
Level of consciousness	awake, able to comprehend	awake, alert / OX3
Extremities: Movement	bilateral weak & equal	weak but able to move
Strength		all extremities
PAIN ASSESSMENT	ø	ø
CARDIOVASCULAR		
Rhthym/Lead	sinus tach @ 106	Sinus tachycardia 110-115
Heart Sounds	S1 S2	
Skin	diaphoretic	cold
Edema	4+ lower extremities, pitting edema	4+ pitting edema Lower Ext.
JVD/ Capillary refill	> 3 secs	Sluggish
Pulses: Radial	1+	1+
Posterior Tibial	unable to palpate	unable to palpate
Dorsalis Pedis		unable to palpate
RESPIRATORY		
Breath Sounds	diminished BS at the bases	clear
Oxygen Delivery	100% Non rebreather mask	100% Non Rebreather Mask
Suctioning/Sputum		
ETT/Trach tube		
Size Placement		
Cough		
Treatments		
GASTROINTESTINAL		
Bowel Sounds	Hypoactive	Hypoactive
Abdomen	Distended, tender to touch	Distended
Date of last BM	?	
NG tube: Placement	(R) Nare	1600
Suction	low cont' suction	Low continuous suction
Drainage	greenish	greenish
GENITORURINARY		
Urine: Color	None.	Amber
Void/Foley	Foley inserted 23 Jul 05	Inserted 23 July '05
INTEGUMENTARY		
Integrity	intact, cyanosis bilateral	Intact
Dressings	lower & upper extremities.	
Dressing Condition		
Drains/Tubes		
Drainage		
Signature	(b)(6)	(b)(6)

POST OPERATIVE DAY	PHYSICIAN

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP								
Pulse								
Respirations								
Temperature								
SaO2								
%O2								
O_2 Delivery								
CVP								
Pain Scale								
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT		5610
OUTPUT		665
DIFFERENCE		

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
IV D5½NS	150	150	150	150	150	150	150	150	1200	~~2400~~ ~~1750~~ 3650
IVBP										750
IV Bolus							1000		1000	1000
PO	30	30					30		90	210
Other										210
TOTAL										5610

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total								95	95	165
NG output	200								200	500
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										665

Legend	
Init=initials	P=Prone
JVD=Jugular Venous Distention	R= Right
L=Left	SaO2=Saturation of Arterial Oxygen
NIBP=Noninvasive Blood Pressure	S= Supine
N=No	ABP= Arterial Blood Pressure
Y= Yes	PS=Pharmacologically Sedated

Name	Signature	Init
(b)(6)		

POST OPERATIVE DAY	PHYSICIAN

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP	100/59	96/55	90/62		89/55	95/65	85/51	80/47
Pulse	113	111	113		115	120	120	127
Respirations	18/14	16/14	16/14		18/14	18/14	16/14	19/14
Temperature								
SaO2	100%	100%	100%		98%	100%	98%	100%
%O2								
O_2 Delivery								
CVP								
Pain Scale	Sedated	Sedated	Sedated		Sedated	Sedated	Sedated	Sedated
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT		
OUTPUT		
DIFFERENCE		

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
VBSLR	150	150	150	150	150	150	150	150		
~~VBP~~ Diprivan	12	12	12	12	12	10	11			
Dopamine	26	26	26	26	26	26	13	13		
IVFB		50								
PO										
Other										
TOTAL										

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total		100/100	30/110	30/140	30/170	30/200	30/230			
NG output										
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										

Legend

Init=initials	P=Prone
JVD=Jugular Venous Distention	R= Right
L=Left	SaO2=Saturation of Arterial Oxygen
NIBP=Noninvasive Blood Pressure	S= Supine
N=No	ABP= Arterial Blood Pressure
Y= Yes	PS=Pharmacologically Sedated

Name	Signature	Init
(b)(6)		

SYSTEM	DAYS	NIGHTS
NEURO		24 JUL 05 2000hrs
Level of consciousness		sedated c Propofol
Extremities: Movement		N/A
Strength		N/A
PAIN ASSESSMENT		N/A
CARDIOVASCULAR		sinus tachycardia c ectopy
Rhthym/Lead		↓
Heart Sounds		S, S2 rrlrd
Skin		intact
Edema		3+ pitting & bilateral LE
JVD/ Capillary refill		no JVD noted; cap refill < 3sec
Pulses: Radial		+/+
Posterior Tibial		+/+
Dorsalis Pedis		+/+
RESPIRATORY		
Breath Sounds		clear to upper lobes anteriorly; coarse crackles ↓ to (R) base
Oxygen Delivery		Vent 700 14 100% Speep AC
Suctioning/Sputum		
ETT/Trach tube		7.5 @ 23 @ lip
Size Placement		Continue pulse oximetry present
Cough		—
Treatments		—
GASTROINTESTINAL		
Bowel Sounds		hypoactive
Abdomen		distended / firm
Date of last BM		
NG tube: Placement		NGT
Suction		LIS
Drainage		bilious
GENITORURINARY		
Urine: Color		clear yellow
Void/Foley		#16 F
INTEGUMENTARY		
Integrity		intact
Dressings		(R) femoral TLC
Dressing Condition		C.D.I.
Drains/Tubes		
Drainage		
Signature		(b)(6)

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

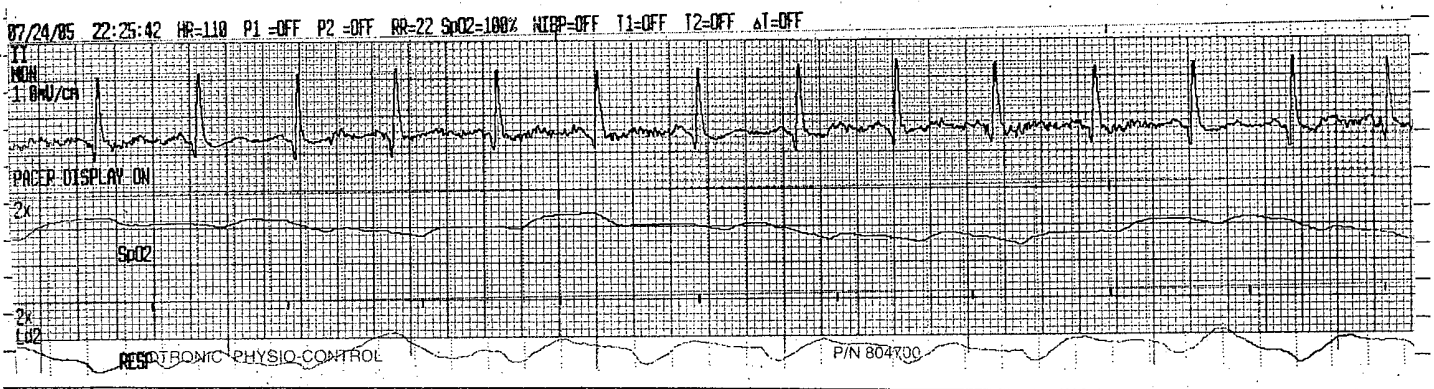
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

PORT TITLE

ICU FLOW SHEET

OTSG APPROVED *(Date)*

EKG STRIPS



VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS

(Continue on reverse)

EPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
		24 JUL 05

TIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, st, middle; grade; date; hospital or medical facility)*

166576 Atawi, Ahmed Ismail

ICU Bed 1

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

A FORM 4700, MAY 78

ACLU DDII CID ROIS 39035

USAPA V2.00

ACLU-RDI 5494 p.154

000158

Exhibit 2

DATE	DIAGNOSIS									HOSPITAL DAY								
Time	07	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22	
NIBP/ ABP														111/63	113/63	101/66	94/62	
Pulse														104	115	109	112	
Respirations														19	14	14/14	14/14	
Temperature														0				
SaO2														94%	98%	100%	100%	
%O2														100%	100%	100%		
O_2 Delivery														Vent AC 700 14 100% Sp-p N/A	Vent AC 700 14 100% Sp-p N/A	Vent AC 700 14 100% Sp-p N/A		
CVP																		
Pain Scale														Sedated	Sedated	Sedated	Sedated	
Pain Med																		
Pt Position														S	S	S	S	

Time	07	08	09	10	11	12	13	14	**Total 8 hr**	15	16	17	18	19	20	21	22	**Total 8 hr**
IV D5LR															150	150	150	
~~IVPB~~																		
Propofol															13	13	13	
Dopamine															26	26	26	
PO																		
Other																		
TOTAL																		

TIME	07	08	09	10	11	12	13	14	**Total 8 hr**	15	16	17	18	19	20	21	22	**Total 8 hr**
Urine output Hour/Total															100/100	60/160	45/205	
NG output																		
Emesis																		
Stool																		
Chest tube #1/ #2																		
Jackson Pratt #1/ #2																		
TOTAL																		

ASPECT	TIME/INITIALS	
Bath/Skin Care		
Oral Care		
Foley Care		
Trach Care		

Safety	D	E	N
High risk for falls	Y N	Y N	Y N
Call bell in reach	Y N	Y N	Y N
Bed position/Locked	Y N	Y N	Y N
Protective device	Y N	Y N	Y N

POST OPERATIVE DAY	PHYSICIAN

TIME	23	24	01	02	03	04	05	06
NIBP/ ABP								
Pulse								
Respirations								
Temperature								
SaO2								
%O2								
O_2 Delivery								
CVP								
Pain Scale								
Pain Med								
Pt Position								

24 Hour Totals	Yesterday	Today
INPUT		
OUTPUT		
DIFFERENCE		

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
IV D5LR	50	50	50	50	50	50	50	50		
IVBP	100									
Ethiran	20	20	20	20	20	20	20	20		
Levophed	47	47	47	47	47	47	47	47		
PO										
Other										
TOTAL										

TIME	23	24	01	02	03	04	05	06	Total 8 hr	TOTAL 24 HRS
Urine output Hour/Total	15/15	15/30	30/60	15/75	15/90	15/105		40/145		
NG output								600		
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										

Legend

Init=initials
CVD=Jugular Venous Distention
L=Left
NIBP=Noninvasive Blood Pressure
N=No
Y= Yes
P=Prone
R= Right
SaO2=Saturation of Arterial Oxygen
S= Supine
ABP= Arterial Blood Pressure
PS=Pharmacologically Sedated

Name	Signature	Init
(b)(6)		
(b)(6)		

SYSTEM	DAYS	NIGHTS
NEURO		25 JUL 05 1945 hrs
Level of consciousness	Pt is sedated	sedated
Extremities: Movement	Pupils (4) 4mm sluggish	sedated
Strength		sedated
PAIN ASSESSMENT	Unable to assess	does not with draw
		pupils 4mm / = / sluggish
CARDIOVASCULAR		
Rhthym/Lead	ST	Sinus Tachycardia 5 ectopy
Heart Sounds	S_1 S_2	S_1 S_2 noted
Skin	Dusky Fingers	cool / dusky to periphy
Edema	(+4) pitting edema	3+ pitt to LLE. 1+ to UE
JVD/ Capillary refill	<5sec	no JVD noted / <3mm cap refill
Pulses: Radial	Trace	+/+ thready
Posterior Tibial	Unable to palpate	unable to palpate
Dorsalis Pedis	Unable to palpate	+/+ weak
RESPIRATORY		
Breath Sounds	Diminished @ side	diminished (L) base, rhonchi
Oxygen Delivery	100% via vent PEEP 5	AC 700
Suctioning/Sputum	Clear white liquid	respirx
ETT/Trach tube	22cm positive	7.5 ETT
Size Placement	22cm	22@ lip line
Cough	—	⊖
Treatments	✓	⊖
GASTROINTESTINAL		
Bowel Sounds	Hyperactive all Quads	hyperactive
Abdomen	Distention noted	distended / tense
Date of last BM		
NG tube: Placement	(R) Nare	checked & in bolus
Suction	120 mm of Hg	LLS
Drainage	50cc	bilious
GENITORURINARY		
Urine: Color	Clear Yellow Ace	amber
Void/Foley	Foley	#16 Fr foley
INTEGUMENTARY		
Integrity	Ecchymosis (R) groin	Op Site (R) groin
Dressings		(R) IJ TLC
Dressing Condition	CDI	clean
Drains/Tubes		
Drainage		
Signature	(b)(6) AC	(b)(6)

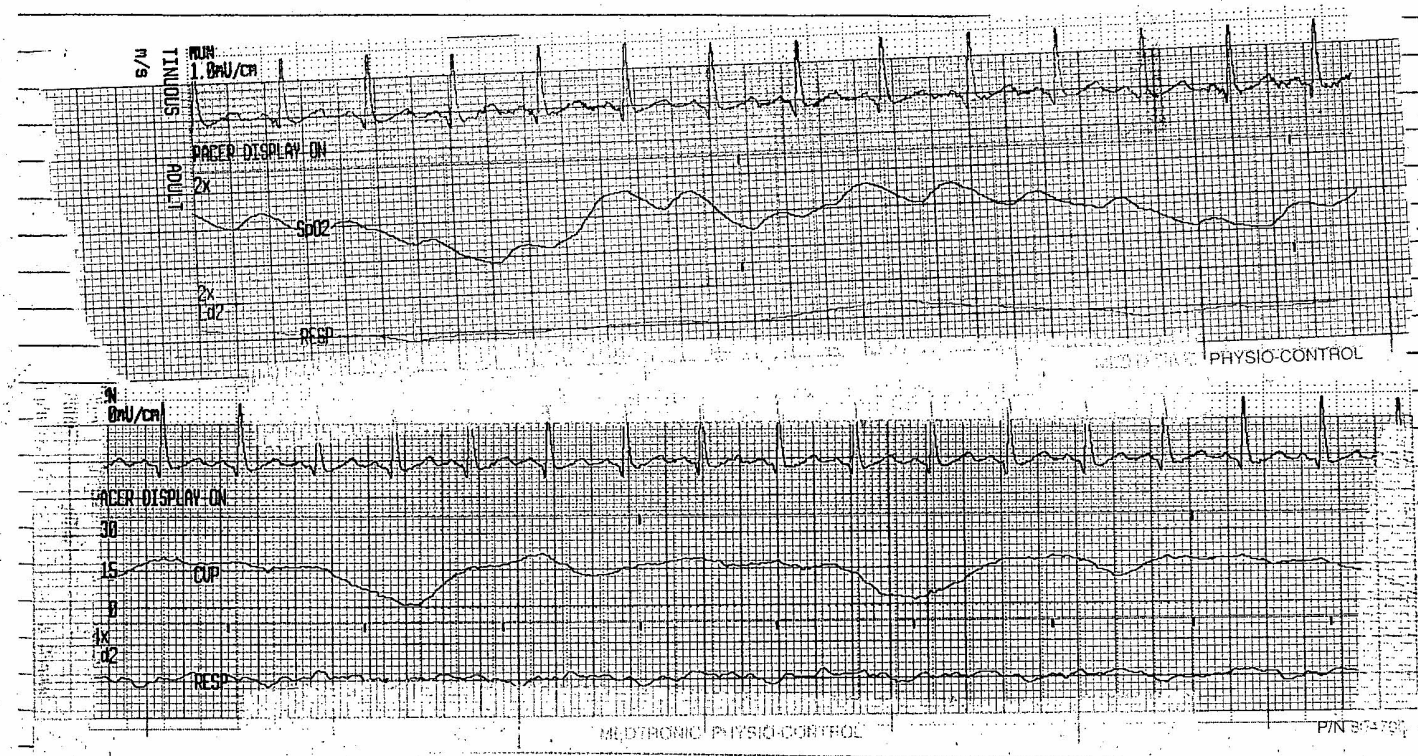
0073-05-CID579-40022

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

PORT TITLE	OTSG APPROVED (Date)
ICU FLOW SHEET	

EKG STRIPS



VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
Arterial (R) groin	25 Jul 05	27 Jul 05	leaking fr site, D/C 25 Jul		05
CVP (R) subclavian 5Fr	25 JUL 05	29 Jul 05	Clean, dry & intact		

(Continue on reverse)

TRACED BY (Signature and Title)	DEPARTMENT/SERVICE/CLINIC	DATE
(b)(6)	ICU Bed 1	26 Jul 05

PATIENT IDENTIFICATION (For types of written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

166576
Alawi, Ahmed Ismail

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700, MAY 78

ACLU DDII CID ROIS 39039

ACLU-RDI 5494 p.158

000162

Exhibit 2

DATE 25 Jul 05 | DIAGNOSIS Malaria | HOSPITAL DAY

Time	07	08	09	10	11	12	13	14		15	16	17	18	19	20	21	22	
IBP/ BP	45/44																	
Pulse	127																	
Respirations	28																	
Temperature	97.8 C																	
SaO2	95%																	
%O2	RA																	
O_2 Delivery	ET																	
CVP																		
ETT = 22cm																		
Pain Scale																		
Pain Med																		
Pt Position																		

Please Refer To V/S Flowsheet

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
V DSLR	150	150	50	60	50	50	50	50		50	50	50	50	50	50	50	50	
VPB					50	50						50						
Dopamine	4 c/hr	16	16	16cc	16cc	16cc	19	19		19	19	19						
Diprivan	12.6%	126	64cc	60cc	60cc													
Heparin Flush			3cc	3cc	3cc	3cc	3cc	3cc	18cc	3cc	3cc	3cc	3	3	3	3	3	
Ativan						10	6	20cc	26cc	20cc	20cc	20cc	20	20	20	20	20	
PO Levophed															56	75	47	
Other Rocephin					50cc	100cc 50cc												
TOTAL																		

D/C 25 Jul 05

Concentration change

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output Hour/Total	0cc	0	60cc	20	20	20	20	20		20	20				30	30	15	
NG output	50																	
Emesis	-																	
Stool	-																	
Chest tube #1/ #2																		
Jackson Pratt #1/ #2																		
TOTAL																		

ASPECT	TIME/INITIALS	
Bath/Skin Care	0930	OL
Oral Care	0930	OL
Foley Care	0930	( )
Trach Care	N/A	

Safety	D	E	N
High risk for falls	(Y) N	Y N	Y N
Call bell in reach	(Y) N	Y N	Y N
Bed position/Locked	(Y) N	Y N	Y N
Protective device	(Y) N	Y N	Y N

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Jul Yr. 05

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 12 13 14 15 16 17 18 19 20 21 22 23 24 25
12 July	(b)(6)	Vit C 250 mg PO bid c meals	0700	X (b)(6) Add See New Order (b)(6)
			1600	
12 July	(b)(6)	FeSO4 325 mg PO bid c meal.	0700	X (b)(6) *
			1600	X
12 July	(b)(6)	Reglan 10mg PO qid - 30 mins before meals and at bedtime	0700	X (b)(6) *
			1100	*
			1600	(b)(6)
			2200	
13 July 2005	(b)(6)	Vitamin C 500 mg PO QD	0800	X (b)(6) changed 14 July 05
14 July	(b)(6)	Doxycycline 100 mg po daily x 14 days	1800	X X (b)(6) 1500 ok
14 July	(b)(6)	Vitamin C 500mg po bid c meal	0700	X X X (b)(6) *
			1600	X X (b)(6)
21 July 2005	(b)(6)	Quinine 650 mg PO TID	1000	Add See New Order 21 July (b)(6)
			1800	
			2200	
21 July 2005	(b)(6)	Mefloquine 250mg X 3 tabs now & 2 tabs 12° later	1500	(b)(6)
			0300	
23 Jul	(b)(6)	IV NS @ 150 c/h	0700	1500 0 70% DC'd 23 July
			1900	
23 Jul	(b)(6)	D5 ½ NS @ 100c		

ALLERGIES: ☐ YES ☒ NO — NKA

PRIMARY DIAGNOSIS: Malaria

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

16657 ICU Bed 1

Atawi, Ahmed Ismail

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

ACLU-DII CID ROI 39041

ACLU-RDI 5494 p.160

000164

DA FORM 4670 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Exhibit 2

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing — Mo. 7 Yr. 2005

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
14 Jul	(b)(6)	Toradol 60mg IM x1 stat	14 Jul	1200	1200	(b)(6)
14 July		Tylenol 650mg po + Benadryl 25 mg po	14 July	12:15	12:15	
15 Jul		Reglan 10mg now IM	15 Jul	2030	2030	
~~15 Jul~~		~~Reglan 10mg IV TID PRN~~ Error see below	15 Jul	PRN		
		~~for nausea~~				
20 Jul		Lasix 20mg P/O x1	20 Jul	1300	1300	
21 July 2005		MSO4 4mg IM x 1 now	21 July 05	1500hrs	1500	
22 July 2005		Percocet I-II PO now	22 July	2030	2030	

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
~~14 Jul~~	(b)(6)	~~Tyl~~ error (b)(6)	
15 July		Reglan 10mg IV.	
		TID PRN for Nausea	
21 July		Tylenol 650mg	21 Jul 0555 (b)(6) 22
		PO PRN for Pain	
21 July 2005		MOM/Viscous Lidocaine/ 15/15cc PO Q6 PRN	
22 July 2005		Percocet I-II	21 Jul 2030 — DC'D 22 July (b)(6)
		~~I~~ Q 4-6 PRN	
22 July 05		Toradol 30mg IM	
		Q6° PRN	

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Jul Yr. 05

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23 24 25 26
23 Jul	(b)(6)	D5 1/2 NS @ 100 cc/hr	07	(b)(6) CHANGED RATE SEE BELOW
			19	
23 July		D5 1/2 NS @ 150 cc/L	2228 HRS	(b)(6)
24 Jul	(b)(6)	Infuse 250 cc of albumen @ 100 cc/hr then resume NS @ 150 cc/hr	07	(b)(6)
			19	
24 Jul	(b)(6)	NS @ 150 cc/hr	07	(b)(6) D/C'd Jul 24 0500 @ 1030 hrs
			19	
24 Jul	(b)(6)	Resume D5 NS (or D5 LR) + Albumin @ 150 cc/hr	07	(b)(6) See transcribed to next sheet
			19	
24 Jul	(b)(6)	Ceftriaxone 1gm IV q 24°	12	(b)(6) transcribed to next sheet
24 Jul				
24 Jul	(b)(6)	Dopamine 2 mcg/kg/min drip start now	13	(b)(6)
24 Jul	(b)(6)	Dopamine 10 mcg/kg/min drip (verbal order	1485	(b)(6) transcribed to next sheet

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
malaria

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO.

PATIENT IDENTIFICATION:
166526
ATAWI, Ahmed Ismael
Exhibit 1

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES
D 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22

Exhibit 2

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. Jul Yr. 05

Verify by Initialing

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
23 Jul	(b)(6)	Dilute 25% albumin IN 500 cc	23 Jul	1615	1615	(b)(6)
		D5W then infuse @ 100cc/hr				
23 Jul		Ceftriaxone 1gm IVP	23 Jul	1615	1630	
23 Jul		D50 1 amp NOW	23 Jul	1615	1615	
23 Jul		Repeat Rocephin 1gm NOW	23 Jul	1700	1700	
24 Jul		D50 1 Amp NOW	24 Jul	NOW	1100	
24 Jul		Cancel NS	24 Jul	NOW	1100	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD | PROGRESS NOTES

DATE	NOTES
13 Jul 05 1030	30 ♂ transfer in from ICU via stretcher accompanied by RNs & (b)(6). Pt condition guarded. Cardiac monitor on. IV NS 500 bolus in progress. Vital signs & assessment done. Please refer to ICU flowsheet. Foley inserted in ICU draining nil. Blood sugar of 46, Dext 50% 1 amp IVP given by RN. Orders received & implemented by RN. Continue to monitor pt. (b)(6) AN
1200.	Foley draining minimal amt of urine along tubing, (b)(6) notified continue observation. O_2 sat 100% O_2 2L/min via NC applied by respiratory therapist. IV NS @ 250 c/h in progress via pump. (b)(6) AN
1330	(b)(6) notified of BP 77/55. Order received & implemented by RN.
1400	Pt turn & repositioned to (R) side with 2 assist. (b)(6) AN
1430.	(b)(6) notified of IV NS X 1 L completed & BP of 82/56. Order received & implemented by RN. Pt turn & repositioned to (L) side @ 2 assist. Sips of H_2O given to pt. (b)(6) AN
1500.	Pt become very diaphoretic. S/B (b)(6) Accucheck done 55
1530	NGT sert inserted to low continous suction draining greenish fluid Accucheck 46, Dext 50% 1 amp IVP given by RN. 100% NRB applied.
1600.	Accucheck 63. ABG drawn. Results noted by (b)(6) Vital signs taken in vital signs flowsheet. NPO instructed.
1630.	IV D5½NS @ 100 c/h & IV Alb 25% / Dext 5% 500 mls @ 100 c/h in progress. IV Rocephin 1gm ↑ @ 1630hrs.

LATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

PART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

IENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
#166576 Atawa Ahmed Ismail ICU Bed 9		

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ISOO/FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.00

ACLU DDII CID ROIS 39045
000168

ACLU-RDI 5494 p.164

Exhibit 2

NE	FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE	NOTES
1700	Patient turn & repositioned. CVP (R) groin resutured by (b)(6) dressing reapplied by RN. Bilateral lower extremities elevated on 1 pillow.
1745	Ventimask 31% applied by respiratory therapist. (b)(6) AN
1800	100% Non Rebreather reapplied by respiratory therapist. O2 sat 98% Accuchek 62, (b)(6) notified, Dext 50% 1 amp IVP given by RN.
1845	pt turned & reposition (L) side c two assist. Pt resting quietly. Continue monitoring. (b)(6) AN.
2000	Received pt a/OX3, O2 4L NC in use c O2 Sat 91%, delivery System changed to Non Rebreather mask c good results (100% Sat) remains tachypneic (RR 40-45). HR 110-115 as per monitor - Sinus tachycardic, BP 87/40 mmHg currently. Central line (R) groin TLC c D5 1/2 NS @ 100 cc/h and 25% Albumin 50ml/500ml D5W @ 100 cc infusing s any complications. pitting Edema +4 of lower extremities, remains hypothermic c T 93.4 F. Blankets in use. NGT to low continuous suction c 200 cc greenish drainage so far, BS (+) hyperactive. latest CLS 119 mg/dl, foley cath insitu c approx 50 ml amber urine in bag. Skin is intact, appears weak but able to move all extremities and able to turn self in bed. Will continue to monitor. (b)(6) ANE
0200	SBP remains less than 90 mmHg, HR up 127, RR 43, urine output last 2 hours approximately 25 ml, as per (b)(6) 1 liter D5 1/2 NS bolus started in addition to 150 cc/h standard infusion. assisted c turning as per pts request occasionally. (b)(6) NE.
0400	SBP improved to over 90 mmHg p 1 liter fluid bolus, latest urine output last 2 hours 95 mL. Monitored close

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD | PROGRESS NOTES

DATE	NOTES
24 July 05	Nutrition: Pt transferred to ICU, NPO c NG to suction c bilious output. Pt c ↑ing abd girth (ascites) labored breathing, uop less than usual c ↑ing BUN 25, Cr 1.3, K+ 5.7 gluc 169 ↑ (Was low 23 July beginning to lose sg 50% Dex. Pt c ↓ BP, ↓ temp, ↑ HR, ↑ RR. Pt has TLC, femoral Would not provide parenteral nutrition as all solutions have from 24.5-30m Eq/L. Additionally unclear wait until pt is hemodynamically stable. Receiving IV albumin to help c diuresis c hopefully ↓ 3rd spacing of fluid. May need to consider Kayexelate if able to tolerate c ↓ NG output. PT is @ ↑ nutrition risk. FU ≤ 3 d. (b)(6) Addendum: Considering adding MVI to D5 1/2 NS one bag/d. (b)(6)
24 Jul 05 0900	Rec. pt supine in bed A+OX3. O2 6L NRB Sat @ 92%. HR = 114 R = 38-48. Central line (R) groin in place infusing Albumin 100 cc/hr 25%. 500ml/NS @ 250ml/hr complications. Pitting edema +4 lower extremities. NG-tube output @ 0900 = 80 cc to continuous suction Foley catheter output = 30 cc/hr amber urine

LATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

PART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

IENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

166576

REGISTER NO. | WARD NO. ICU

PROGRESS NOTES

NE	FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE	NOTES (24 Jul 05 NSG) (b)(6)
July 05	Pt able to turn by himself in bed – will continue to
2000	monitor (b)(6)
200	Pt diaphoretic, cold/clammy VS= B 74/43 P 96
	RR 38 T 92.4 O^2 8L NRB urine output minimal
	Pt asleep (b)(6)
July	NSG: Pt diaphoretic – breathing labored –
300	RT hyperventilating pt & BVM. (b)(6)
	present – 2mg Vecuronium given IV
	B 211/174 P = 95 R = 26
05	2 mg Vecuronium given IV
	BP 198/154 HR 101
308	pt intubated by Respiratory therapist (b)(6)
	ET tube = 7.5 mm, 22 cm @ lip
310	pt given Valium 10 mg.
315	B/P taken 54 palp
317	BP 67/33 R 18 HR 102
325	Dopamine increased to 40mg/hr BP: 86/39
✓	HR 101 RR 16
340	HR 106 B/P 90/34 RR 16
1420	Diprivan 3ml/hr BP 108/56 HR 114 R 23
600	Diprivan increased to 5ml/hr B 131/43 P 106 RR 4 O^2 = 62
700	BP = 99/66 P = 112 R = 20 O^2 = 97%
	(b)(6)

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD | PROGRESS NOTES

DATE	NOTES
24 July 2005	Anesthesia note: Called to ICU for airway estab. Pt. intubated by (b)(6) 7.5 ETT @ 22cm at lip. Equal BBS c̄ equal chest expansion. ETT [illegible] 1cm above carina per CXR. Taped midline. Lacrilube applied OU; taped shut. (b)(6)
24 Jul 05	Diprivan increased to 7ml/hr (b)(6)
VSG 1730	Dopamine decreased to 30 ml/hr (b)(6)
	~~Sodium Bicarbonate~~ (b)(6)
1830	Diprivan increased to 8ml/hr / Pt showing signs of agonal breathing (b)(6)
24 JUL 05 1945hrs	Received supine in bed in no apparent distress. Noted to have Dopamine and Propofol infusing per MD order. Light sedation maintained. Lung sounds clear to upper lobes bilaterally. Noted to have diminished sounds to left base. 7.5 ETT in place, taped 22cm @ lip. Good O_2 sats noted. Vital signs stable. Report received from (b)(6) (b)(6)
2300hrs	Status unchanged. No [illegible] change [illegible] output. Vital signs remain stable. (b)(6)
0100hrs	Ventilator alarm sounding. Noted to need battery pack replacement. Evaluated by (b)(6) (respiratory) and determined to be functioning normally on AC (b)(6)

LATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST / FIRST / MI	SPONSOR'S ID NUMBER (SSN or Other)

PART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

IENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO.

#166576

Ismael

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

Exhibit 2

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5 JULOS	Blood pressure noted to be lower. Demand Propofol drip
0500 hrs	d/c d/c'd as ordered effect noted. Ventilator Change-out performed d/c
	(b)(6) due to continuing alarm status. Pt remained
	ventilated via ambu bag by R.N. during change over. Good
	O2 sats noted pre and post procedure. (b)(6)
0720	Pt is sedated, pupils 4mm sluggish response, ST rhythm noted, S1 S2
	present, +4 pitting edema noted, < 3sec cap refill, unable to
	assess dorsalis pedis pulse, Trace radial, diminished @ bases
	Breath sound. Pt on Vent with PEEP of 5 ETT placement at
	22cm. Pt has an NG tube in (R) Nare. Check placement confirmed. CXR ordered.
	Pt has hyperactive BS all quads. Slight distention noted in abdomen.
	Pt has foley catheter draining amber yellow clear urine. CVP on (R)
	groin has slight leakage. (b)(6) notified to re-insert central
	line. For V/S please refer to flowsheet (b)(6)
0930	Central Line reinsertion SVR performed by (b)(6) on (R)
	subclavian. Dressing CDI. Lasix 20mg given stat. IV Diprovan
	decreased to 6 cc/hr. D5LR decreased to 50cc/hr. HOB raised
	to 30° SF. X-Ray for central line placement confirmed (b)(6)
1639	New Diprovan placed to pt (b)(6)
1130	Change Pt linen, provided ADL care for pt. Turn pt to (R) side q 2hr.
1240	Pt received 50cc of Reglan and administering 50cc of Zantac.
	Pt also received 2cc of Reglan (10mg) via IVP. Reinforced CVL line
	dsg. Reassessed pt. Pt status remains unchanged from previous
	assessment. Pt started on IV Ativan @ 8cc/hr. D/C Diprovan
	@ 1800. CVP is 26. (b)(6)

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD | PROGRESS NOTES

DATE	NOTES
1230	Vent setting FIO2 70, 14, TVol 700, peep 5. Respiratory therapist, (b)(6) is weaning O2 down to 50%. (b)(6)
1330.	ET suctioning done, small amt of thick whitish mucus. (b)(6) AN
1400	Pt unable to tolerate turning, ↓ BP. Reposition semi fowler HOB 30°. (b)(6)
1600	S/B (b)(6) & (b)(6) Orders received & implemented by RN (b)(6)
1700	FIO2 ↓ 40%, saturating @ 98%. Hourly accucheks done (b)(6)
1730	BP ↓ F 66/32, IV Dopamine titrate to 8.2 mcg. (b)(6)
1745	↑ IV Levophed titrate for SBP > 80 mmHg (b)(6)
1807	FS was 70. (b)(6) notified. D50 was given stat @ 1824 Recheck FS in 1 hr (b)(6)
1836	Accucheck 100, will check again @ 2000 hrs. (b)(6)
1930hrs	Received Clt in Sem tonbin in no apparent distress. Noted to have Ativan infusing and Levophed drip in place. B/P found to be low, Levophed titrated. Good O2 sats noted. (b)(6) aware of findings. (b)(6)
2000hrs	Increased Levophed to 20mcg/min for hypotension (b)(6)
2030hrs	Increase in B/P noted (b)(6)
2300hrs	Levophed increased to 25mcg/min. Remainder of vital signs stable (b)(6) of stat. (b)(6)

LATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | (SSN or Other)

PART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

IENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade).* | REGISTER NO. | WARD NO.

#166576

ACLU-RDI 5494 p.170 ACLU DDII CID ROIS 39051

A / AWOL, ATTACHED Issued/ LCI 7th 1

NE	FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE	NOTES
1200hrs	Status unchanged. Blood pressure remain stable on Levophed at 25mcg/min. Vital signs stable (b)(6)
1600hrs	Status unchanged. Labs obtained, ABG obtained. Remained too unstable throughout the night to turn and position. Blood pressure would not tolerate turning. (b)(6)
0800hrs	AM care done S/B (b)(6). Accuchek done. Vital signs taken, assessment done. Please refer to ICU flowsheet. IV Ativan 24mg/NS 250cc @ 21c/h. IV Levophed 8mg/NS 250cc @ 47c/h. IV DSLR @ 50c/h. ET tape changed by (b)(6); position changed to (R) side (b)(6) ~~Accuchek done~~
1000	Pt turned & repositioned to (L) side with 2 assist. Continue monitoring. (b)(6)
1200	(b)(6) notified of temp 101.2°F. Will see pt. (b)(6)
1300	S/B (b)(6) orders received & implemented by RN. Tylenol 500mg give via NGT. (b)(6)
1430	CVP (R) subclavian dressing changed by RN. T° ↓ 99°F
1600	IV Lasix 40mg IVP given by RN. BP ↓ 69/36mmHg. IV Levophed ↑ to 70c/hr (37 mcg). (b)(6) notified, no order received (b)(6).
1800	On hourly accuchek, PM care done with 2 assist Pt turned & repositioned to Right side, bilateral heels elevated on blanket. Stage 1 decubitus sacral noted. Lotion/powder applied to site. IV Ativan ↓ to 10cc (1mg)/hr.
1845	Patient status unchanged. (b)(6)

0073-05-CID579-40022

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo July Yr 05

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initial
23 Jul	(b)(6)	ABG	23 Jul	1615	1615	(b)(6)
23 Jul		KUB upright	23 Jul	1615	1615	
23 Jul		~~Abdo~~ error Repeat KUB in 6 hrs (b)(6)	23 Jul	2300		
24 Jul		KUB	24 Jul	1030	1030	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

Exhibit 2

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo Jul Yr 05

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME
23 Jul	(b)(6)	accu-check q hour
		give Dextrose 50% 1 amp IVP if glucose < 70
		Finger stick glucose Q1° until >100 for 2 successive sticks then Q4°

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

HR	DATE COMPLETED 23	24	25	26	27
01	\	\	X	X	78
02	\	\	100	100	76
03	\	\	X	X	86
04	\	\	X	97	94
05	\	168	X	104	85
06	\	\	107	106	
07	\	147	X	76	
08	\	\	X	86	61
09	\	110	X	100	90
10	\	\	105	110	101
11	\	152	X	100	98
12	\	\	X	X	81
13	\	\	X	X	81
14	\	112	92	115	
15	\	\	101	66	
16	46	100	97	70	
17	41	/	103	79	
18	62	162	70	85	
19	83	X	100	89	
20	119	X	94	91	
21	136	X	101	94	
22	X	110	104	78	
23	X	X		76	
24	140	X	101	84	
~~05~~					
~~09~~					
~~13~~					
~~17~~					
~~21~~					

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Malaria

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: _____

PATIENT IDENTIFICATION:
165716
Atawi, Ahmed Ismael
Icu Bed 1

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. Jul Yr. 05

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
24 Jul	(b)(6)	2 Amp bicarb to IVP (Current maintenance)	24 Jul	1430	1620	(b)(6)
24 Jul		Lasix 40mg IVP x 1	24 Jul	1705	1730	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED

Exhibit 2

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)
For use of this form see AR 40-407; the proponent agency is the Office of The Surgeon General.

Month Jul Yr. 05

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 24	25	26	27
25 Jul 05	(b)(6)	IV Ativan 1-2 mg/hr to	0700		(b)(6)		
	-----	keep sedated	1900		(b)(6)		
25 Jul 05	(b)(6)	IV D5LR to 50 ml/hr	0700		(b)(6)		
	-----		1900		(b)(6)		
25 Jul 05	-----	Norepinephrine drip start	0700		(b)(6)		
	-----	@ 10 mcg/min & titrate to	1900		(b)		D/C 26 Jul 05
	-----	keep SBP > 80	X	X			
25 Jul 05	(b)(6)	Flagyl 500mg IV Q8°	0600		(b)(6)		
	-----		1400		(b)(6)		
	-----		2200		(b)(6)		
26 Jul 05	(b)(6)	Lasix 40mg IV Q12H	1000		(b)(6)		D/C 27 Jul 05
	-----		2200		(b)(6)		
26 Jul 05	(b)(6)	Zantac 50mg IV Q12	1000		(b)(6)		
	-----		2200		(b)(6)		
26 Jul 05	(b)(6)	IV Levophed 8mg/NS 250cc	0700		(b)(6)	(b)(6)	
	-----	titrate to keep SBP ≥ 90	1900		(b)(6)		
27 Jul 05	(b)(6)	IV Epinephrine 2mg/D5 250cc	0700			1000 d/c	
	-----	(8 mcg/cc) @ 24 mcg/min &	1900				
	-----	titrate for SBP > 80					

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: Malaria

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO. _____

PATIENT IDENTIFICATION:
1660576
ATAWI, Ahmed Ismael
ICU #1

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. JUL Yr. 05

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
25 Jul	(b)(6)	Lasix 20mg IVP	25 Jul	STAT	0730	(b)(6)
25 Jul 05		Dextrose 50% 1 AMP IVP	25 Jul 05	STAT	1830	
26 Jul		Dextrose 50% 1 amp IVP	26 Jul	stat	0700	
26 Jul		Gentamycin 240mg IV X1	26 Jul	ASAP	1330	
26 Jul		IVP Lasix 40mg @	26 Jul	1600	1600	
26 Jul		Dext 50% 1 amp IVP	26 Jul	1530	1530	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
26 Jul	(b)(6)	Tylenol 500mg per NGT	26 Jul 0800	27 Jul 0900											
------	------	or per rectum TID prn	(b)(6) NGT	NGT											
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CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. July Yr. '05

VERIFY ORDERS

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23 24 25 26 27 28
(b)(6) 23 JULY	(b)(6)	REGLAN 10mg IV Q4°	03 07 11 15 19 23	(b)(6) (b)(6) (b)(6)
24 Jul	(b)(6)	Diprivan @ 10 mcg/kg/mm ⇒ 3cc/hr and titrate for Sedation	14 19	(b)(6) D/c 25 Jul 05
24 Jul		2 Amp bicarb to IVF (current maintenance bag)	14	(b)(6) D/c 25 Jul 05
(b)(6) 24 Jul	(b)(6)	D5NS (or D5LR) Albumin @ 150 cc/hr	09 19	(b)(6) (b)(6) D/c 25 Jul 05
(b)(6) 24 Jul	(b)(6)	Ceftriaxone 1gm IV q 24°	12	(b)(6)
(b)(6) 24 Jul	(b)(6)	Dopamine ↑ 10mcg/kg/min drip	14 19	(b)(6) D/c 25 Jul 05
(b)(6) 24 Jul	(b)(6)	IV (b)(6) Zantac ~~IVP~~ 50mg q6	05 11 17 23	(b)(6) (b)(6) D/c 26 Jul 05

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

MALARIA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

166576 ICU BED #1

ATAWI, AHMED ISMAIL

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14	
E	15	16	17	18	19	20	21	22	
N	23	24	01	02	03	04	05	06	

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

0073-05-CID579-40022

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo _____ Yr ____

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initi
23 Jul	(b)(6)	Place foley catheter	23 Jul		1030	(b)(6)
23 Jul		Dext 1 amp IVP	23 Jul		1045	
23 Jul		NS @ 250 c/h x 1 L	23 Jul		1203	
23 Jul		IV NS @ 500 c bolus	23 Jul		1030	
24 Jul		ABG in 1 hour	24 Jul	1620	1620	
24 Jul		ABG in 1 hour	24 Jul	1805	1805	
24 Jul		BMP	24 Jul	1830	1830	
25 Jul		CBC, Chem 8, ABG & CXR in AM	26 Jul	0600	0530	
26 Jul		CBC, Chem 8, ABG	~~26 Jul~~ 27 Jul	0600	0530	

Order/ Expir Date	Clerk/ Nurse	PRN. ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo July Yr. 05

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME
4 July 05	(b)(6)	V/S Routine
4 July 05	(b)(6)	Regular Diet Double Portions meat Sauce + Ensure with each meal
4 July	(b)(6)	Bathrm Priv (fall)
6 July 05	(b)(6)	Fluid Restrictions 1 Liter / day
23 Jul	(b)(6)	NGT to continuous suction
24 Jul	(b)(6)	Vent Settings IMV 14
		Tidal Volume 600 FO2 100%
24 Jul	(b)(6)	TV ↑ 700 PEEP 5
25 JUL	(b)(6)	Bed turns Q2H
25 JUL 05	(b)(6)	↓ FIO2 to 70%-40%

HR | DATE COMPLETED

18 19 20 21 22 23 24 25 26 27

2000 (b)(6)
1900 (b)(6)
0800 (b)(6) NPO NPO D/C 25 JUL 05
1930 (b)(6)
0700 (b)(6) D/C 25 JUL 05
1900 (b)(6)
0700 (b)(6)
1900 (b)(6)
0700 (b)(6)
1900 (b)(6)
0700 (b)(6)
1900 (b)(6)

ALLERGIES: ☐ YES ☒ NO NKA

PRIMARY DIAGNOSIS: Malaria

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

165576

ICU Bed 1

~~#~~

Atawi, Ahmed Ismail ~~1665~~

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms): Atawi, Ahmed Ismail Detainee # 166576	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
ORGANIZATION Organisation: 344th Combat Support Hospital	NATION *(e.g. United States)* Pays: Iraq	DATE OF BIRTH Date de naissance	SEX Sexe: ☑ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil	RELIGION Culte
☑ CAUCASOID Caucasique	☐ SINGLE Célibataire	☐ DIVORCED Divorcé
☐ NEGROID Négroïde	☐ MARRIED Marié	☐ SEPARATED Séparé
☐ OTHER (Specify) Autre *(Spécifier)*	☐ WIDOWED Veuf	☐ PROTESTANT Protestant
		☑ CATHOLIC Catholique
		☐ JEWISH Juif
		☐ OTHER *(Specify)* Autre *(Spécifier)*

NAME OF NEXT OF KIN Nom du plus proche parent:

RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit:

STREET ADDRESS Domicilé à (Rue):

CITY OF TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris):

MEDICAL STATEMENT Declaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [1] Maladie ou condition directement responsable de la mort	Septic Shock, Multiorgan failure	
ANTECEDENT CAUSES — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	Hepatic failure	
Symptômes précurseurs de la mort — UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire	Malnutrition Resistant Malaria	
OTHER SIGNIFICANT CONDITIONS [2] Autres conditions significatives [2]		

MODE OF DEATH Condition de décès		
☐ NATURAL Mort naturelle	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☐ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitees par des causes exterieures
☐ ACCIDENT Mort accidentelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
☐ SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
☐ HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident à Avion ☐ YES Oui ☐ NO Non

DATE OF DEATH *(Hour, day, month, year)* Date de décès *(l'heure, le jour, le mois, l'année)*:

PLACE OF DEATH Lieu de décès:

I HAVE VEIWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci dessus

NAME OF MEDICAL OFFICER Nom du médicin militaire ou du médicin sanitaire: (b)(6)

TITLE OR DEGREE Titre ou diplômé:

GRADE Grade:

INSTALLATION OR ADDRESS Installation ou adresse: TF 344 MED TF CAMB BUCCA

DATE Date: 27 jul 2005

SIGNATURE Signature: (b)(6)

[1] State disease, injury, or complication which caused death, but not the mechanism of death, but not related to the disease or condition causing death.
[1] Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc
[2] Préiser la condition qui a contribué à la mort, mais non reliée à la maladie ou à l'état pathologique provoquant le décès

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40400; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL

NAME AND LOCATION OF HOSPITAL: 34TH Combat Support Hospital

Instructions - Medical Officer in attendance will:

Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.

Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*	2. TIME OF DEATH *(Hour-day-month-year)*	3. MEDICAL EXAMINER/ CORONER'S CASE
Atawi, Ahmed Ismail ICU Bed 1 #166576	1529, 27-July-2005	☐ YES ☒ NO
	4. RELIGION	5. CHAPLAIN NOTIFIED ☐ YES ☒ NO
	6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH	

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* Septic Shock, multiorgan failure	4 days
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1) Hepatic failure	74 Weeks (unknown)
	(2) Resistant Malaria	> 1 month
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a. Malnutrition	> 1 month
	b.	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE
27 Jul 2005	(b)(6)	(b)(6)

SECTION B - ADMINISTRATIVE ACTI

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☒ NO	21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY	25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
26. DATE	27. TYPED NAME AND GRADE OF REGISTRAR	28. SIGNATURE OF REGISTRAR

DA FORM 3894-R, 1 JUL 77 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED. USAPA V2.01

000185

Exhibit 3

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
(b)(6)

FINAL AUTOPSY EXAMINATION REPORT

Name: Atawi-Al Alwani, Ahmed Ismail
ISN: US9IZ-166576CI
Date of Birth: 01 January 1975
Date of Death: 27 July 2005
Date of Autopsy: 04 August 2005
Date of Report: 24 October 2005

Autopsy No.: ME (b)(6)
AFIP No. (b)(6)
Rank: CIV
Place of Death: Iraq
Place of Autopsy: Port Mortuary
Dover AFB, DE

Circumstances of Death: This 30 year old male civilian detainee was reportedly admitted to the Camp Bucca Security Hospital for complications of malaria.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471.

Identification: Identification is established by identification tags present on the body.

CAUSE OF DEATH: Peritonitis due to small bowel perforation.

MANNER OF DEATH: Natural.

FINAL AUTOPSY DIAGNOSES

I. Gastrointestinal system:
   A. Small bowel perforation.
      1. Adjacent pseudocyst formation with rupture.
      2. Ascites (4000 ml of feculent tan fluid).
      3. Peritonitis.
   B. Neoplastic mesenteric masses (2) adjacent to pseudocyst.
   C. Moderate to severe hepatic steatosis.

II. Respiratory system:
   A. Bilateral pulmonary congestion (right 800 gm, left 750 gm).
      1. Bilateral pleural effusions (right 200 ml, left 100 ml).

III. No evidence of trauma.

IV. Toxicology: Lidocaine, mefloquine, chloroquine, metoclopramide, lorazepam, oxycodone and oxymorphone are present.

EXTERNAL EXAMINATION

The body is that of a well-developed male that weighs 177 pounds, is 68 inches in length and appears compatable with the reported age of 30 years. Lividity is fixed on the posterior surface of the body except in areas exposed to pressure. Rigor has passed. The scalp hair is black. Facial hair consists of a black mustache and whisker stubble. The irides are dark. The corneae are cloudy. The conjunctivae are unremarkable. The sclerae are white. The external auditory canals, external nares and oral cavity are free of foreign material and abnormal secretions. The teeth are natural and in good condition. A ¾ inch scar is present on the right side of the chin. The neck is straight, and the trachea is midline and mobile. The chest is unremarkable. The abdomen is mildly protuberant. The fingernails are intact. The upper and lower extremities are symmetric. There are multiple scars on the anterior surface of the right knee. An identification tag is present on the left wrist, bearing the following information "Atawi, Ahmed Ismail, US9IZ-166576CI, DOB 01 Jan 1975". The genitalia are those of a normal adult male. There is a 4 x 4 inch area of discoloration with early pressure ulceration present on the superior aspect of the gluteal cleft.

EVIDENCE OF MEDICAL THERAPY

1. An endotracheal tube.
2. Nasogastric tube.
3. Foley catheter with drainage bag.
4. Healing therapeutic needle puncture site in the left antecubital fossa.
5. Monitor lead pads on the upper and mid chest and flanks, bilaterally.
6. Defibrillator pad on the left chest and the left back.

EVIDENCE OF INJURY

None.

INTERNAL EXAMINATION

BODY CAVITIES:

The sternum is visibly and palpably intact. No excess fluid is present in the pericardium. Approximately 200 ml of amber fluid is present in the right chest cavity and 100 ml in the left. The abdominal cavity contains approximately 4000 ml of tan feculent fluid. Yellow-tan fibrinous material covers multiple loops of the small bowel, omentum and portions of the liver. The organs occupy their usual anatomic positions.

HEAD:

The scalp is reflected. The calvarium of the skull is removed. The leptomeninges are thin and delicate. Coronal sections demonstrate sharp demarcation between white and grey matter. The ventricles are of normal size. The brain weighs 1420 gm. The atlanto-occipital joint is stable.

NECK:

The anterior strap muscles of the neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid are intact. The larynx is lined by intact white mucosa. The thyroid is symmetric and red-brown. The tongue is free of bite marks, hemorrhage, or other injuries.

RESPIRATORY SYSTEM:

The right and left lungs weigh 800 and 750 gm, respectively. The external surfaces are smooth and deep red-purple. The pulmonary parenchyma is diffusely congested and edematous. No mass lesions or areas of consolidation are present.

CARDIOVASCULAR SYSTEM:

The 290 gm heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries arise normally, follow the usual distribution and are widely patent without evidence of significant atherosclerosis or thrombosis. The myocardium is homogenous, red-brown, and firm. The valve leaflets are thin and mobile. The endocardium is smooth and glistening. The ascending aorta gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.

LIVER & BILIARY SYSTEM:

The 2010 gm liver has an intact capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture. No mass lesions or other abnormalities are seen. The gallbladder contains approximately 10 ml of green-black bile. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:

The 290 gm spleen has a smooth, intact, red-purple capsule. The parenchyma is maroon and congested, with distinct Malpighian corpuscles.

PANCREAS:

The pancreas is soft and yellow-tan, with the usual lobular architecture. No mass lesions or other abnormalities are seen.

ADRENAL GLANDS:

The right and left adrenal glands are symmetric, with bright yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:

The right kidney weighs 180 gm and the left 150 gm. The external surfaces are intact and smooth. The cut surfaces are red-tan and congested, with uniformly thick cortices and sharp corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course

and caliber. Tan bladder mucosa overlies an intact bladder wall. The bladder is empty. The prostate is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are palpably free of mass lesions.

GASTROINTESTINAL TRACT:

The esophagus is lined by smooth, grey-white mucosa. The stomach is empty. The gastric wall is intact. The serosal surfaces of the small and large bowel are covered by tan-yellow fibrinous material. A fluid and fecal filled pseudocyst measuring 7 inches in greatest diameter is present just inferior and posterior to the stomach and adjacent to a portion of the duodenum. Reflection of the stomach reveals an area of rupture on the anterior surface of the pseudocyst. Dissection and further reflection show the pseudocyst to be in continuity with a perforation of the adjacent duodenum. Two solid mass lesions measuring 3 ½ x 2 inches and 2 ½ x 1 inch are present and appear to be arising from the region of the mesenteric root. The larger lesion is firmly adherent to the duodenum in the region of the perforation. The appendix is unremarkable.

MICROSCOPIC EXAMINATION

1. Heart (slide 1): No significant microscopic abnormalities.
2. Spleen (slide 2): No microscopic abnormality noted.
3. Kidneys (slide 4): Moderate arteriolosclerosis.
4. Liver (slide 2): Moderate to severe steatosis.
5. Brain (slide 5): No microscopic abnormality noted.
6. Lungs (slide 3): Pulmonary alveolar congestion.
7. Omentum: (slide 6): Acute serositis.
8. Abdominal masses (slides 7-10): Confluent areas of necrosis with intervening areas composed of atypical dyshesive cells with coarse nuclear chromatin and frequent plasmacytoid features. Occasional mitoses are present.
9. Region of perforation of the pseudocyst (slides 11,12): Fibroadipose tissue with fibrin deposition, acute inflammatory infiltration and granulation tissue formation.

ADDITIONAL PROCEDURES/REMARKS

- Documentary photographs are taken by the OAFME staff photographer.
- Specimens retained for toxicologic testing and/or DNA identification are: blood, vitreous, bile, gastric contents, kidney, lung, brain, spleen, liver, adipose and psoas muscle.
- Full body radiographs are obtained.
- The dissected organs are forwarded with the body.
- Personal effects are released to the attending investigative agency and appropriate mortuary operations representatives.

OPINION

This reported 30 year-old male civilian detainee died of peritonitis due to small bowel perforation. According to reports, the decedent was admitted to the hospital with a diagnosis of hepatic failure. Further workup showed an advanced stage of malaria. His clinical course was complicated by multi-system organ failure and he ultimately succumbed to septic shock on his 23rd hospital day.

AUTOPSY REPORT ME (b)(6)
ATAWI, Ahmed Ismail

Autopsy examination showed 4 liters of feculent ascites and mesenteric mass lesions with adjacent small bowel perforation. It appears that initially the area of perforation was walled off forming a "pseudocystic" structure that ultimately ruptured. Initial microscopic examination of the mesenteric masses showed them to be neoplastic, however their exact etiology is pending specialty consultation. An addendum report will be issued upon its completion.

Postmortem toxicologic analysis revealed the presence of the therapeutic agents lidocaine, mefloquine, chloroquine, metoclopramide, oxycodone and oxymorphone in the urine. Lorazapam was present in the blood at a therapeutic level (0.26 mg/L).

The manner of death is natural.

(b)(6)

(b)(6) Medical Examiner

(0141-05-CID112)

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
(b)(6)

PRELIMINARY AUTOPSY REPORT

Name: Atawi-Al Alwani, Ahmed Ismail
ISN: US9IZ-166576CI
Date of Birth: 01 January 1975
Date of Death: 27 July 2005
Date of Autopsy: 04 August 2005
Date of Report: 06 August 2005

Autopsy No.: ME (b)(6)
AFIP No.: Pending
Rank: CIV
Place of Death: Iraq
Place of Autopsy: Port Mortuary
Dover AFB, DE

Circumstances of Death: This 30 year old male civilian detainee reportedly died at the Camp Bucca Security Hospital.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471.

Identification: Identification is established by identification tags present on the body.

CAUSE OF DEATH: Peritonitis due to small bowel perforation.

MANNER OF DEATH: Natural.

PRELIMINARY AUTOPSY DIAGNOSES:

I. Gastrointestinal system:
   A. Subacute small bowel perforation.
      1. Adjacent pseudocyst formation with rupture.
      2. Ascites (4000 ml of flocculent tan fluid).
   B. Mesenteric masses (2) adjacent to pseudocyst.

II. Respiratory system:
   A. Bilateral pulmonary congestion (right 800 gm, left 750 gm).
      1. Bilateral pleural effusions (right 200 ml, left 100 ml).

III. No evidence of trauma.

IV. Toxicology pending.

(b)(6)

(b)(6) Medical Examiner

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.